This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0089 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2024 9:21 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BALL MEMORIAL HOSPITAL (15-0089) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Jor	n Vanator	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jon Vanator			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		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	333, 786	98, 806	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	45, 010	-41		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	378, 796	98, 765	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

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

Health Financial Systems

BALL MEMORIAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0089

Period:
From 01/01/2023

Part I

H0SPI	TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi de	er CCN: 1		Peri od:		Workshe	et S-2	
						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	nared:
								5/24/20		
	1.00	2.00		3. 00		4	4. 00			
1. 00	Hospital and Hospital Health Care Co Street: 2401 UNIVERSITY AVENUE	pmplex Address: PO Box:								1.00
2.00	City: MUNCIE	State: IN	Zip Code	: 47303-	3428 Count	y: DELAWARE				2.00
2.00	ior ty. moner 2	Component Name	CCN	CBSA	Provi der	7	Payme	nt Syst	em (P,	2.00
		·	Number	Number	Type	Certi fi ed		0, or		
		1.00	0.00		1.00		V	XVIII		
	Hospital and Hospital-Based Componer	1.00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	
3.00	Hospi tal	BALL MEMORIAL HOSPITAL	150089	34620	1	07/01/1966	N	Р	Р	3. 00
4.00	Subprovider - IPF									4. 00
5.00	Subprovider - IRF	BMH PHYSICAL REHAB	15T089	34620	5	07/01/1986	N	P	0	5. 00
6.00	Subprovi der - (Other)									6. 00
7. 00 8. 00	Swing Beds - SNF Swing Beds - NF	1								7. 00 8. 00
9. 00	Hospi tal -Based SNF									9. 00
10.00	Hospi tal -Based NF									10.00
11. 00	Hospi tal -Based OLTC									11. 00
12.00	Hospi tal -Based HHA									12.00
13.00	Separately Certified ASC Hospital-Based Hospice									13. 00 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	0ther					From:		To	-	19. 00
						1.00		2. (
20. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20. 00
21. 00	Type of Control (see instructions)					2				21. 00
					1 00	0.00				
	Inpatient PPS Information				1. 00	2. 00		3. 0	00	
22. 00	Does this facility qualify and is it	currently receiving pay	ments for		Υ	N				22. 00
	di sproporti onate share hospi tal adju	stment, in accordance wi	th 42 CFR							
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for		endment							
22. 01	Did this hospital receive interim UC		al UCPs. 1	for	Υ	Y				22. 01
	this cost reporting period? Enter in									
	for the portion of the cost reporting									
	1. Enter in column 2, "Y" for yes or cost reporting period occurring on co		tion of the	9						
	instructions)	arter october 1. (see								
22. 02	Is this a newly merged hospital that	requires a final UCP to	be		N	N				22. 02
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in for the portion of the cost reportin			10,						
22. 03	Did this hospital receive a geograph	ic reclassification from	urban to		N	N	İ	N		22. 03
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c			I						
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for			r						
	reporting period occurring on or aft									
	Does this hospital contain at least			s						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" for	r						
22 04	yes or "N" for no. Did this hospital receive a geograph	ic real assification from	urban ta							22. 04
22. 04	rural as a result of the revised OMB			I						22.04
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin			r						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft Does this hospital contain at least			_						
	counted in accordance with 42 CFR 41			I						
	yes or "N" for no.	,								
23. 00	Which method is used to determine Me					3 N				23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method		-	I						
	reporting period different from the			551						
	reporting period? In column 2, ente									

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 9: 21 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 1 60.01 instructions) IME Direct GME IME Direct GME 1.00 2.00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 12.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or 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 61 04 surgery 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' 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 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Unweighted IME Unweighted Program Name Program Code FTF Count Direct GME FTE Count 1.00 2. 00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents 0. 00 0.00 61.10 for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 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 instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 0.00 62.00 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62. 01 0.00 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 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 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

	<u>Financial Systems</u> TAL AND HOSPITAL HEALTH CARE COMP		MEMORIAL HOSPITAL ATA Provider CO		ri od:	u of Form CMS-2 Worksheet S-2	2552-10
	Odm			Fr To	rom 01/01/2023 12/31/2023	Part I Date/Time Prep 5/24/2024 9:21	
				Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
				1.00	2.00	3. 00	
	Section 5504 of the ACA Base Year			This base year	is your cost r	reporting	
4. 00	period that begins on or after of Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column	yes, or your facili der of unweighted no stations occurring in number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	2. 75	15. 74	0. 148729	64.00
	or (cordillir r drvrded by (cordillir	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
		1. 00	2.00	Si te 3.00	4.00	5. 00	
5. 00	Enter in column 1, if line 63	FAMILY MEDICINE	1350	3. 00	21. 04		65 OC
o5. 01	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 at ivided by (column 3 + column 4)). (see instructions)	INTERNAL MEDICINE	1400	4. 25	13. 76		65. 01
				Unwei ghted		Ratio (col. 1/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te	позрі таї	2))	
				1.00	2. 00	3.00	
	Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
6 00	beginning on or after July 1, 20 Enter in column 1 the number of		ry care resident	0. 35	10. 65	0. 031818	66 00
0.00	FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0. 33	10.00	0.031010	00.00
	TOO. SHIFT I GIVE GOOD BY COOLUMN 1 T	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
		1.00	2.00	Si te	4.00	F 00	
7. 00	Enter in column 1, the program	1.00 FAMILY MEDICINE	2.00	3. 00	4. 00 18. 90	5. 00 0. 224774	67 00
30	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			5. 10	13.70		2
	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						
7. 01	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)	INT MEDICINE	1400	2. 84	50. 43	0. 053313	

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 9: 21 am 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 68.00 68.00 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 subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 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 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 Ν 0 76.00 Ν recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 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. 80 00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 85.00 N 86.00 |Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 Ν 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν 0 88.00 amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. Wkst. A Line Effective Date Approved No. Permanent Adjustment Amount Per Di scharge 1.00 2.00 3.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.00 0 89.00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XI X 1 00 2 00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N 90.00 Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in 91.00 91.00 Ν N full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 93.00 Ν Ν Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν 94.00 94.00 Ν applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 95.00 0.00 0.00 95.00 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00

N

117. 00

118. 00

"N" for no.

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	BALL MEMORIA					u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	CN: 15-0089		1/01/2023 2/31/2023		epared:
						1.00	_
147.00 Was there a change in the statist	cal hasis? Enter "V" for	ves or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of						N	148. 00
149.00 Was there a change to the simplif				or no.		N	149.00
	<u> </u>	Part A	Part B		tle V	Title XIX	
		1.00	2. 00		3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or						3. 13)	
155. 00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157. 00 Subprovi der – IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	N.		N	NI NI	158. 00
160.00 HOME HEALTH AGENCY		N N	l N l N		N N	N N	159. 00 160. 00
161. 00 CMHC		IN	l N		N	N	161. 00
TOT. GO CWITC					11		101.00
Mul +i compue						1.00	
Multicampus 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more campu	ses in dif	ferent CB	SAs?	N	165. 00
Effect 1 101 yes of N 101 He.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	166. 00
						1.00	-
Health Information Technology (HI	Γ) incentive in the Americ	can Recovery and	d Reinvestm	ent Act		1.00	
167.00 Is this provider a meaningful use						Υ	167. 00
168.00 If this provider is a CAH (line 1			e 167 is "Y	'), enter	the		168. 00
reasonable cost incurred for the last 168.01 of this provider is a CAH and is	•	,	nualify f	or a hard	shi n		168. 01
exception under §413.70(a)(6)(ii)					5111 P		100.0
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") and				nter the	9.9	99169.00
13. 2 1. 3 1. 2020. 1. (200 111511 4011				Beg	gi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporti ng				170. 00
					1. 00	2.00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (9	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter		Y		36 171. 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 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/24/2024 9:21 am Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE 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 1 00 Has the provider changed ownership immediately prior to the beginning of the cost 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, 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 management Υ 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? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 02/22/2024 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 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 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching 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 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Υ 15.00 Part B Y/N Y/N Date 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? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/01/2024 04/01/2024 17 00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems BALL MEMORIA	AL HOSPITAL		In Lie	u of Form CM	IS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CO	CN: 15-0089	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/24/2024 S	Prepared:
		Descri	pti on	Y/N	Y/N	
	to and	()	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	report data for other; bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPLTALS)		1. 00	
	Capital Related Cost	IT OHI EDILENS H	OSI I IAES)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	'If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see	N	31. 00
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvices furnishe	d through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instructions 32 is yes, were the requirements of Sec. 2135.2 application, see instructions.	uctions.				33. 00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an a lf yes, see instructions.	arrangement wit	h provider-b	ased physicians?	Y	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exilohysicians during the cost reporting period? If yes, see in		ts with the	provi der-based	N	35. 00
	TENTE TO SECURE SECTION OF THE POST OF THE POST OF THE			Y/N	Date	
				1. 00	2. 00	
0/ 05	Home Office Costs					0, 05
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the home of the home			N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other see instructions.			γ Υ		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	IU HEALTH				42. 00
	preparer.			DUTTED - LUNE (1. T	U 0DC	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@I UHEALTI	n. UKG	43. 00

Heal th	Financial Systems BALL MEM	ORI AL	HOSPI TA	L		In Lie	u of Form CMS-	2552-10
H0SPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi	der CCN: 15-0089		eri od:	Worksheet S-2	!
					To	rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre 5/24/2024 9:2	pared: 1 am
				3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	D	I RECTOR,	GOVERNMENT				41.00
	held by the cost report preparer in columns 1, 2, and 3	, Р	ROGRAMS					
	respecti vel y.							
42.00	Enter the employer/company name of the cost report							42.00
	preparer.							
43.00	Enter the telephone number and email address of the cos	t						43.00
	report preparer in columns 1 and 2, respectively.							

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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0089

				T	o 12/31/2023	Date/Time Pre 5/24/2024 9: 2	
						I/P Days / 0/P	ı aiii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	omponent	Li ne No.	No. or bods	Avai I abl e	ONITY RET HOUTS	11 110 1	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00	2.00	0.00	1. 00	0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	244	89, 060	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and					_	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		244	89, 060	0.00	0	7. 00
	beds) (see instructions)			•			
8.00	INTENSIVE CARE UNIT	31. 00	36	13, 140	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00	o	0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00	21	7, 665	0.00	0	12. 00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		301	109, 865	0.00	0	14. 00
15.00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16.00	SUBPROVI DER - I PF	40. 00	o	0		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	16	5, 840		0	17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		317				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance 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)		8	2, 920			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	1	365		0	34. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

outpatient days (see instructions)

LTCH non-covered days

Provider CCN: 15-0089 Peri od: From 01/01/2023 Part I

Date/Time Prepared: 12/31/2023 5/24/2024 9:21 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 18, 938 2, 497 60, 453 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 21, 734 15, 349 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 631 4.00 1.349 Hospital Adults & Peds. Swing Bed SNF 5.00 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 2, 497 7.00 18, 938 60, 453 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 2,280 380 8, 360 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 10.00 BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT 11.00 11.00 NEONATAL INTENSIVE CARE UNIT 12.00 0 370 2, 923 12.00 13.00 NURSERY 1,539 2, 228 13.00 Total (see instructions) 4, 786 73, 964 14.00 21, 218 59. 10 1, 772. 37 14.00 CAH visits 15.00 0 15.00 15.10 REH hours and visits 0 C 0 15.10 16.00 SUBPROVIDER - IPF 0 C 0 0.00 0.00 16.00 SUBPROVIDER - IRF 17.00 1,917 107 4, 846 0.00 24.89 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 518 24. 10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26.25 Total (sum of lines 14-26) 1, 797. 26 27.00 27.00 59. 10 28 00 Observation Bed Days 219 10, 472 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 0 Employee discount days - IRF 31.00 0 31.00

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Health Financial Systems BALL MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0089

Full Time Equivalents Nonpaid Title V Title XVII Title XIX Patients Pati						12/31/2023	5/24/2024 9: 2	
PART I - STATISTICAL DATA					Di sch	arges		
PART I - STATISTICAL DATA 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 1.00 1.0		Component		Title V	Title XVIII	Title XIX		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed. (Diservation Bed and Hospice days) (see instructions for col. 2 7 for the portion of LDP room available beds) 7			11. 00	12. 00	13.00	14. 00	15. 00	
8 exclude Swing Bed, Observation Bed and Hospice days) (See Instructions for col. 2 for the portion of LDP room available beds)								
2.00	1. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		C	4, 191	516	13, 787	1. 00
3. 00 HMO IPF Subprovider	2.00	HMO and other (see instructions)			3, 526	2, 902		2.00
4. 00 HMO I RF Subprovi der	3.00	,						3.00
5.00		•				57		1
6.00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		1				- 1		1
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTERSIVE CARE UNIT 8.00 0.00 CORONARY CARE UNIT 10.00 11.00 0.00 URSI INTERSIVE CARE UNIT 10.00 11.00 0.00 URSI INTERSIVE CARE UNIT 11.00 11.00 11.00 0.00		, .						1
8. 00 INTENSIVE CARE UNIT		Total Adults and Peds. (exclude observation						
9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 TOTAL (see instructions) 15. 00 CAH visits 15. 00 CAH visits 15. 10 REH hours and visits 15. 10 REH hours and visits 15. 10 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IPF 19. 00 SUBPROVIDER - IRF 20. 00 INSING FACILITY 20. 00 THER LONG TERM CARE 20. 00 HORSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HORSING FACILITY 22. 00 OTHER LONG TERM CARE 24. 10 HOSPICE 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 25 FEDERALLY OUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Department of lines 14-26) 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 31. 00 LTCH sit neutral days (see instructions) 31. 01 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	8.00	, ,						8.00
11.00 SURGICAL INTENSIVE CARE UNIT 12.00	9.00	CORONARY CARE UNIT						9. 00
12. 00 13. 00 13. 00 13. 00 13. 00 14. 01 15. 10 15	10.00	BURN INTENSIVE CARE UNIT						10.00
13. 00 NURSERY	11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
14. 00 Total (see instructions) 15. 00 CAH visits 15. 10 REH hours and visits 15. 10 SUBPROVIDER - IPF 0. 00 O 0 0 0 0 0 16. 00 17. 00 SUBPROVIDER - IRF 0. 00 O 0 0 0 0 0 16. 00 19. 00 SUBLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 O'THER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 32. 01 LTCH non-covered days 33. 00 LTCH site neutral days and discharges 0. 00 O O O O O O O O O O O O O O O O O	12.00	NEONATAL INTENSIVE CARE UNIT						12.00
15. 00 CAH visits 15. 10 REH hours and visits 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER - IRF 19. 00 SUBPROVI DER 19. 00 SKI LLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH U QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee di scount days (see instruction) 31. 00 Employee di scount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH site neutral days and discharges	13.00	NURSERY						13.00
15. 00 CAH visits 15. 10 REH hours and visits 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER - IRF 19. 00 SUBPROVI DER 19. 00 SKI LLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH U QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee di scount days (see instruction) 31. 00 Employee di scount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH site neutral days and discharges	14.00	Total (see instructions)	0.00	C	4, 191	516	13, 787	14. 00
16. 00 SUBPROVI DER - IPF 0. 00 0 0 0 0 0 16. 00 17. 00 SUBPROVI DER - IRF 0. 00 0 159 10 391 17. 00 18. 00 19. 00 159 10 391 17. 00 18. 00 19.	15.00	CAH visits						15. 00
17. 00 SUBPROVIDER - IRF 0. 00 0 159 10 391 17. 00 18. 00 SUBPROVIDER 18. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 00 24. 10 HOSPICE 24. 10 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 25. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 00servation Bed Days 28. 00 29. 00 Ambul ance Trips 29. 00 28. 00 00servation Bed count days (see instruction) 28. 00 00servation Bed iscount days (see instruction) 31. 00 25. 01 25.	15. 10	REH hours and visits						15. 10
18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 21. 00 10 THER LONG TERM CARE 22. 00 23. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 20. 00 2	16.00	SUBPROVI DER - I PF	0.00	C	o	o	0	16. 00
19. 00	17.00	SUBPROVI DER - I RF	0.00	C	159	10	391	17. 00
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges	18.00	SUBPROVI DER						18. 00
21.00 OTHER LONG TERM CARE 400 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 44.00 HOSPICE 44.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 28.00 Observation Bed Days 29.00 Ambul ance Trips Employee discount days (see instruction) 31.00 Employee discount days - IRF 21.00 22.00 23.00 23.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days LTCH site neutral days and discharges 21.00 22.00 22.00 23.00 24.00 24.10 25.00 26.00 27.00 26.00 27.00 28.00 29.00 29.00 29.00 29.00 30.00 29.00 30.00	19.00	SKILLED NURSING FACILITY						19. 00
22.00 23.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 24.00 HOSPICE (non-distinct part) 24.00 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 27.00 Observation Bed Days 28.00 29.00 Ambulance Trips 28.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery como outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33.01 LTCH site neutral days and discharges 0 33.01	20.00	NURSING FACILITY						20.00
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Deservation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	21.00	OTHER LONG TERM CARE						21. 00
24. 00 24. 10 HOSPICE HOSPICE (non-distinct part) 25. 00 CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER 26. 00 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) Employee discount days - IRF 31. 00 22. 00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH site neutral days and discharges	22.00	HOME HEALTH AGENCY						22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 26. 27	23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 31. 00 UTCH site neutral days and discharges	24.00	HOSPI CE						24. 00
26. 00 26. 25 27. 00 Total (sum of lines 14-26) 20. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) 31. 00 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 31. 00 33. 01 LTCH site neutral days and discharges	24. 10	HOSPICE (non-distinct part)						24. 10
26. 25 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 31. 00 33. 01 LTCH site neutral days and discharges	25.00	CMHC - CMHC						25. 00
27. 00 Total (sum of lines 14-26) 0.00 27. 00 28. 00 29.	26.00	RURAL HEALTH CLINIC						26. 00
28. 00 Observation Bed Days 28. 00 29. 00 30. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 31. 00 29. 00 31. 00 29. 00 32. 00 32. 01 32. 01 32. 01 33. 00 29. 01 33. 00 29. 01 33. 00 29. 01 33. 01 20. 01 29. 01 29. 02 29. 0	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 29.00 30.00 31.00 31.00 32.00 33.00 33.01	27. 00	Total (sum of lines 14-26)	0.00					27. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 30.00 31.00 31.00 31.00 32.01	28.00	Observation Bed Days						28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 32.00 32.01 0 33.00	29. 00	Ambul ance Tri ps						29. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 32.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	Employee discount days (see instruction)						30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	Employee discount days - IRF						31. 00
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01	32.00	Labor & delivery days (see instructions)						32. 00
33.00 LTCH non-covered days 0 33.00 33.01 LTCH si te neutral days and discharges 0 33.01	32. 01							32. 01
33.01 LTCH site neutral days and discharges 0 33.01		outpatient days (see instructions)						
					1			
34.00 Temporary Expansion COVID-19 PHE Acute Care					0			1
	34. 00	Temporary Expansion COVID-19 PHE Acute Care				1		34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0089

					T-	o 12/31/2023		
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	,	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	135, 246, 550	-605, 090	134, 641, 460	3, 738, 301. 72	36. 02	1.00
2. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4.00	B Physician-Part A -		C	0	0	0.00	0. 00	4. 00
	Admi ni strati ve		F.4. 700		54.700			
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		54, 789 C	l	54, 789 0	2, 096. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for		C		0	0. 00	0. 00	6. 00
0.00	hospital-based RHC and FQHC		C			0.00	0.00	0.00
7. 00	services Interns & residents (in an	21. 00	C	81, 166	81, 166	4, 440. 00	18. 28	7. 00
	approved program)		4 000 001		·			
7. 01	Contracted interns and residents (in an approved		4, 802, 291	0	4, 802, 291	126, 371. 44	38. 00	7. 01
8. 00	programs) Home office and/or related		C		0	0. 00	0. 00	8. 00
	organization personnel		-					
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	5, 181, 748	554, 949	0 5, 736, 697	0. 00 151, 536. 46		
	instructions) OTHER WAGES & RELATED COSTS					·		
11. 00	Contract Labor: Direct Patient		7, 518, 141	0	7, 518, 141	59, 790. 17	125. 74	11. 00
12. 00	Care Contract Labor: Top Level		C	0	0	0. 00	0.00	12. 00
.2.00	management and other		_			0.00	0.00	.2.00
	management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		5, 003, 199	0	5, 003, 199	42, 623. 63	117. 38	13. 00
14. 00	Home office and/or related		C	0	0	0.00	0. 00	14. 00
	organization salaries and wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		45, 763, 752	l	45, 763, 752	1, 090, 129. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A		C	1	ő	0.00		
16. 00	- Administrative Home office and Contract		C	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		C			0. 00	0.00	16. 01
	- Teachi ng		C					
16. 02	Home office contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 02
17.00	WAGE-RELATED COSTS		25 542 543		25 542 547			17.00
17. 00	Wage-related costs (core) (see instructions)		35, 543, 547	0	35, 543, 547			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00	Excluded areas		1, 536, 192	. 0	1, 536, 192			19. 00
20. 00	Non-physician anesthetist Part A		C	0	0			20.00
21. 00	Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A -		C	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		18, 523	0	18, 523			22. 01
23. 00	Physician Part B		C	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		32, 308	0	32, 308			24. 00 25. 00
25. 50	approved program) Home office wage-related		12, 196, 277					25. 50
	(core)				12, 170, 277			
25. 51	Related organization wage-related (core)		С	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		C	0	0			25. 52
	wage-related (core)							

					Т	o 12/31/2023	Date/Time Prep 5/24/2024 9: 2	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			•	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE			_	_			
26. 00	Employee Benefits Department	4. 00	0	0	0	0.00		26. 00
27. 00	Administrative & General	5. 00	9, 983, 377					
28. 00	Administrative & General under		244, 605	0	244, 605	2, 064. 25	118. 50	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	2, 727, 409			i i		29. 00
30. 00	Operation of Plant	7. 00	1, 544, 358	-36, 246	1, 508, 112	i i		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32. 00	Housekeepi ng	9. 00	3, 615, 533					
33. 00	Housekeeping under contract (see instructions)		370, 856	0	370, 856	10, 473. 00	35. 41	33. 00
34.00	Di etary	10. 00	3, 027, 854	-874, 701	2, 153, 153	96, 162. 31	22. 39	34.00
35. 00	Di etary under contract (see instructions)		447, 764	0	447, 764	11, 953. 60	37. 46	35. 00
36.00	Cafeteri a	11. 00	0	837, 109	837, 109	51, 037. 00	16. 40	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38.00	Nursing Administration	13. 00	5, 240, 722	-1, 052, 154	4, 188, 568	88, 542. 57	47. 31	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	6, 565, 803	-327, 082	6, 238, 721	127, 484. 52	48. 94	40. 00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0. 00	41. 00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	1, 892, 324	-101	1, 892, 223	66, 096. 52	28. 63	43.00

Health Financial Systems

BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0089

Period: Worksheet S-3

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0089 Worksheet S-3 Peri od: From 01/01/2023 To 12/31/2023 Part III Date/Time Prepared: 5/24/2024 9:21 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . (from Salaries in col . 5) Worksheet A-6) 3) col. 4 1.00 2.00 6.00 5.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 131, 452, 695 -686, 256 130, 766, 439 3, 629, 885. 13 1.00 36. 02 instructions) 2.00 5, 181, 748 554, 949 5, 736, 697 151, 536. 46 37. 86 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 126, 270, 947 -1, 241, 205 125, 029, 742 3, 478, 348. 67 35.95 3.00 minus line 2) 4.00 Subtotal other wages & related 58, 285, 092 58, 285, 092 1, 192, 542. 80 48.87 4.00 costs (see inst.) Subtotal wage-related costs 5.00 47, 739, 824 Ω 47, 739, 824 0.00 38. 18 5.00 (see inst.)

-1, 241, 205

-2, 957, 942

231, 054, 658

32, 702, 663

4, 670, 891. 47

1, 014, 441. 10

232, 295, 863

35, 660, 605

6.00

7.00

49 47

32. 24

Total (sum of lines 3 thru 5)

Total overhead cost (see

instructions)

6.00

7.00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0089	Peri od: Worksheet S-3
		From 01/01/2023 Part IV

	To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	5, 071, 510	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)	•	1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	•	
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	20, 319, 485	8. 02
8. 03	Health Insurance (Purchased)	0	•
9. 00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	436, 308	10.00
	Life Insurance (If employee is owner or beneficiary)	167, 503	1
	Accident Insurance (If employee is owner or beneficiary)	0	ı
	Disability Insurance (If employee is owner or beneficiary)	605, 090	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	667, 303	15. 00
16. 00	·	0	1
	Noncumulative portion)		
	TAXES	•	
17.00	FICA-Employers Portion Only	9, 863, 372	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	37, 130, 571	24. 00
	Part B - Other than Core Related Cost		1
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
		•	

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0089 F	Peri od:	Worksheet S-3	
	F	rom 01/01/2023	Part V	
		o 12/31/2023	Date/Time Pre	pared:
			5/24/2024 9: 2	1 am
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identif	i cati on:			
1 00		7 540 444	07 400 570	

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	7, 518, 141	37, 130, 570	1.00
2.00	Hospi tal	7, 518, 141	37, 130, 570	2. 00
3.00	SUBPROVI DER - I PF	0	0	3. 00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA			11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17.00	RENAL DIALYSIS I	0	0	17. 00
18. 00	Other	o	0	18. 00

Hoal th	Financial Systems BALL MEMORIAL HO	CDI TAI		In Lie	u of Form CMS-2	0552 1A
		Provider CCN:		Period: From 01/01/2023 To 12/31/2023	Worksheet S-10	0 pared:
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				11 00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)				0. 177858	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				72, 435, 718	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		rom Medica	i d?	Υ	4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			0	5. 00
6.00	Medi cai d charges				469, 619, 658	•
7.00	Medicaid cost (line 1 times line 6)	:	>		83, 525, 613	•
8. 00	Difference between net revenue and costs for Medicaid program (ons)		11, 089, 895	8. 00
9. 00	Children's Health Insurance Program (CHIP) (see instructions for	each fine)			0	9. 00
10.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12. 00	Difference between net revenue and costs for stand-alone CHIP (coo instructi	one)		0	
12.00	Other state or local government indigent care program (see inst				U	12.00
13. 00	Net revenue from state or local indigent care program (Not incl)	333, 038	13. 00
14. 00	Charges for patients covered under state or local indigent care				1, 906, 853	
14.00	10)	program (Not	. Ther daed	111 111103 0 01	1, 700, 033	14.00
15. 00	State or local indigent care program cost (line 1 times line 14)			339, 149	15. 00
16. 00	Difference between net revenue and costs for state or local ind		ogram (see	instructions)	6, 111	
	Grants, donations and total unreimbursed cost for Medicaid, CHII					
	instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to fu	nding charity	/ care		0	17. 00
18.00	Government grants, appropriations or transfers for support of h				0	18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent car	re programs	(sum of lines	11, 096, 006	19. 00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)		00 170		00.000 :	
20.00	Charity care charges and uninsured discounts (see instructions)		28, 172, 05		30, 890, 433	
21. 00	Cost of patients approved for charity care and uninsured discou	nts (see	5, 010, 62	5 1, 201, 303	6, 211, 928	21. 00
22. 00	instructions) Payments received from patients for amounts previously written	off as	25, 83	3 6, 375	32, 208	22. 00
22 00	charity care		4, 984, 79	1 104 020	4 170 720	22 00
23. 00	Cost of charity care (see instructions)		4, 904, 79	2 1, 194, 928	6, 179, 720	23.00
					1.00	
24. 00	Does the amount on line 20 col. 2, include charges for patient imposed on patients covered by Medicaid or other indigent care		a length of	stay limit	N	24. 00
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit		are program	's length of	0	25. 00
25. 01	Charges for insured patients' liability (see instructions)				1, 845, 276	25. 01
26. 00	Bad debt amount (see instructions)				17, 218, 906	
27. 00	Medicare reimbursable bad debts (see instructions)				554, 050	
27. 01	Medicare allowable bad debts (see instructions)				852, 384	
	Non-Medicare had debt amount (see instructions)				16 366 522	

16, 366, 522

3, 209, 251 29. 00 9, 388, 971 30. 00 20, 484, 977 31. 00

28.00

27.00 Medicare reimbursable bad debts (see instructions)
27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

OSPI TAI	L UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	:N: 15-0089	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prep 5/24/2024 9:2	pare
					1. 00	
Р	ART II - HOSPITAL DATA					
U	ncompensated and Indigent Care Cost-to-Charge Ratio					
00	Cost to charge ratio (see instructions)				0. 176823	1.
M	ledicaid (see instructions for each line)					
	Net revenue from Medicaid					2.
	Did you receive DSH or supplemental payments from Medicaid?					3.
- 1	fline 3 is yes, does line 2 include all DSH and/or supplement			ni d?		4.
	fline 4 is no, then enter DSH and/or supplemental payments fr	om Medicai	d			5.
	Medicaid charges					6.
- 1	Medicaid cost (line 1 times line 6)					7.
	Difference between net revenue and costs for Medicaid program (8
	children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)			
	Net revenue from stand-alone CHIP					9
	Stand-alone CHIP charges					10
	Stand-alone CHIP cost (line 1 times line 10)	ooo laatau	ationa)			11 12
	Difference between net revenue and costs for stand-alone CHIP (12
	ther state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl					13
	Charges for patients covered under state or local indigent care					14
	10)	: program (i	NOT THE dued	TILLINGS 6 01		'4
	State or local indigent care program cost (line 1 times line 14	.)				15
	Difference between net revenue and costs for state or local ind		program (see	instructions)		16
	rants, donations and total unreimbursed cost for Medicaid, CHI				s (see	
	nstructions for each line)			,		
00 F	Private grants, donations, or endowment income restricted to fu	indi ng char	ity care			17
00 0	Government grants, appropriations or transfers for support of h	ospital op	erati ons			18
	Total unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines		19
8	3, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	\vdash
			1.00	2. 00	3. 00	
	Incompensated care cost (see instructions for each line)		00 470 0	-4 0 740 000	20.000.400	
4	Charity care charges and uninsured discounts (see instructions)	•	28, 172, 05		30, 890, 433	
	Cost of patients approved for charity care and uninsured discounstructions)	ints (see	4, 981, 46	1, 199, 393	6, 180, 860	21
- 1	Payments received from patients for amounts previously written	off as	25, 83	6, 375	32, 208	22
	charity care	orr as	25, 00	0, 373	32, 200	~~
1	Cost of charity care (see instructions)		4, 955, 63	1, 193, 018	6, 148, 652	23
00 10	sost of chartty care (see thistructions)		4, 755, 60	1, 173, 010	0, 140, 032	23
					1. 00	
00 [Does the amount on line 20 col. 2, include charges for patient	days beyon	d a Length of	stav limit	N	24
	mposed on patients covered by Medicaid or other indigent care			· · · · · · · · · ·	**	
	fline 24 is yes, enter the charges for patient days beyond th		care program	n's Length of	0	25
	stay limit	. 3	1, 3, 4,	. 3 .	-	ĺ
1	Charges for insured patients' liability (see instructions)				1, 845, 276	25
	Bad debt amount (see instructions)				17, 215, 758	26
00 1	Medicare reimbursable bad debts (see instructions)				548, 262	27
. 01 N	Medicare allowable bad debts (see instructions)				843, 480	27
00 1	Non-Medicare bad debt amount (see instructions)				16, 372, 278	
	Cost of non-Medicare and non-reimbursable Medicare bad debt amo				3 190 213	

3, 190, 213 29. 00 9, 338, 865 30. 00 9, 338, 865 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

	FINANCIAL SYSTEMS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	E EADENGES RAFF MEMORIAL	Provi der C	ON: 15 0000 [Peri od:	Worksheet A	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF INTAL BALANCE O	F EXPENSES	Provider C	F	From 01/01/2023 fo 12/31/2023	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/24/2024 9: 2 Recl assi fi ed	1 am
	dost deliter bescription	Sararres	Other	+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1, 656, 465	1, 656, 465	24, 072, 819	25, 729, 284	
3.00	00300 OTHER CAPITAL RELATED COSTS		702 202	702.20	0	0	3.00
4. 00 5. 01	OO400 EMPLOYEE BENEFITS DEPARTMENT O1160 COMMUNI CATIONS	671, 276	783, 392 305, 141			26, 526, 261 769, 472	1
5. 02	00550 DATA PROCESSING	0/1,2/0	0 0	770, 41	0	0	1
5.04	00570 ADMI TTI NG	3, 227, 068	1, 092, 925	4, 319, 993	-652, 848	3, 667, 145	
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	100 701 105	0	0	5. 05
5. 06 6. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	6, 085, 033 2, 727, 409	103, 706, 152 19, 319, 580			104, 097, 552 10, 513, 269	1
7. 00	00700 OPERATION OF PLANT	1, 544, 358	887, 249			8, 371, 755	1
8.00	00800 LAUNDRY & LINEN SERVICE	О	0	(., ,	1, 314, 072	1
9.00	00900 HOUSEKEEPI NG	3, 615, 533	3, 012, 117			5, 152, 314	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 027, 854	1, 810, 644	4, 838, 498		2, 914, 643 1, 202, 680	
13. 00	01300 NURSI NG ADMI NI STRATI ON	5, 240, 722	4, 462, 597	`			
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 315, 752			11, 913, 614	14. 00
15.00	01500 PHARMACY	6, 565, 803	52, 104, 510	58, 670, 313	-50, 011, 472	8, 658, 841	1
16. 00 18. 00	01600 MEDICAL RECORDS & LIBRARY 01080 PATIENT TRANSPORTATION	1, 892, 324	520, 069	2, 412, 393	0 3 -359, 801	0 2, 052, 592	16. 00 18. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	1, 692, 324	520, 009	2, 412, 37	4, 864, 011	4, 864, 011	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	539, 350	8, 755, 436	9, 294, 786			
23. 00	02300 PARAMED ED PRGM	79, 024	33, 230	112, 254	138, 377	250, 631	23. 00
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	28, 963, 478	37, 320, 321	66, 283, 799	-8, 139, 229	58, 144, 570	30.00
31. 00	03100 INTENSIVE CARE UNIT	7, 916, 215	5, 495, 169			10, 980, 409	1
32. 00	03200 CORONARY CARE UNIT	0	0	(0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	2, 309, 353	2, 897, 669	5, 207, 022	-1, 038, 156	4, 168, 866	1
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0 1, 996, 512	0 728, 997	2, 725, 509	0 -412, 799	0 2, 312, 710	40.00
43.00	04300 NURSERY	1, 440, 512	720, 997	2, 725, 50		618, 280	1
	ANCILLARY SERVICE COST CENTERS	- 1					1
50.00	05000 OPERATI NG ROOM	6, 549, 746	36, 430, 438			21, 955, 744	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	2, 166, 030 2, 741, 876	1, 292, 431 4, 873, 759			2, 612, 243 4, 821, 263	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 035, 481	12, 555, 050				1
57.00	05700 CT SCAN	1, 411, 973	1, 041, 944	2, 453, 917	-769, 487	1, 684, 430	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	12 174 4/2	15 (27 02)	0	0	00.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2, 462, 571 1, 476	13, 174, 462 17, 083, 042			2, 855, 399 17, 084, 366	
60. 01	06001 BLOOD LABORATORY	0	0	(0	1
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	1, 471, 401			1, 471, 401	
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	3, 410, 664 501, 746	3, 175, 747 359, 414			5, 124, 840 678, 695	
66. 00	06600 PHYSI CAL THERAPY	6, 157, 598	2, 658, 792			7, 312, 806	1
67. 00	06700 OCCUPATI ONAL THERAPY	865, 699	339, 485			1, 170, 177	
68. 00	06800 SPEECH PATHOLOGY	550, 690	210, 582			688, 668	1
68. 01 69. 00	O6801 AUDI OLOGY O6900 ELECTROCARDI OLOGY	0 1, 719, 570	0 1, 604, 468	3, 324, 038	-	0 2, 404, 826	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 719, 570	1, 604, 466	3, 324, 030	13, 546, 638	13, 546, 638	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	o	0	· ·	11, 115, 864	11, 115, 864	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(52, 199, 006	52, 199, 006	1
73. 01 74. 00	07301 HOSPITAL BASED RETAIL PHARMACIES 07400 RENAL DIALYSIS	2, 044, 604	11, 332, 089 1, 673, 720			23, 351, 565 1, 637, 054	1
76.00	03160 CARDI OPULMONARY		1, 673, 720	1,073,720) -30,000	1, 657, 054	1
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 056, 735	477, 567	1, 534, 302	-283, 224	1, 251, 078	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	677, 406	1, 632, 190	2, 309, 596		1, 642, 210	
77. 00 78. 00	O7700 ALLOGENEIC HSCT ACQUISITION O7800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	
76.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0)	0	78.00
90.00	09000 CLI NI C	0	0	(0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	434, 629	648, 936			985, 466	
90. 02 90. 03	O9002 PAIN CLINIC O9003 ONCOLOGY CLINIC	335, 276 2, 818, 579	541, 699 2, 426, 498			705, 928 3, 593, 817	1
91.00	09100 EMERGENCY	9, 826, 581	7, 993, 210			14, 369, 886	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		, -, =, -	, , ,	1, 11, 130		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	970, 096	477, 073	1, 447, 169	-282, 099	1, 165, 070	92. 01
0E 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0	0	,		0	95. 00
	10200 AMBULANCE SERVICES 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0		102.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE		0	(0	0	113. 00
	<u> </u>				<u> </u>		

Health Financial Systems		BALL MEMORIAL				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJU:	STMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der Co	CN: 15-0089	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
Cost Center D	escrintion	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	1 alli
oost center b	CSCI I P EI OII	our un res	Other	+ col . 2)	ons (See A-6)	Trial Balance	
					(222 11 2)	(col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
118.00 SUBTOTALS (SU	M OF LINES 1 through 117)	132, 140, 338	369, 681, 412	501, 821, 750	11, 298, 078	513, 119, 828	118. 00
NONREI MBURSABLE COS							
190. 00 19000 GIFT, FLOWER,	COFFEE SHOP & CANTEEN	267, 508	518, 272	785, 780	-47, 382	738, 398	190. 00
191. 00 19100 RESEARCH		743, 893	231, 340	975, 23	3 -159, 569	815, 664	191. 00
194.00 07950 OTHER NONREIM	BURSABLE COST CENTERS	0	0		0	0	194. 00
194.01 07951 BSU PHARMACY		0	0		0		194. 01
194. 02 07952 PAVILLION PHA	RMACY	1, 053, 052	9, 477, 435	10, 530, 48	7 -10, 530, 487	0	194. 02
194. 03 07953 VENDI NG		0	0		0 0		1.,
194. 04 07954 CARELI NE		0	0		0 0	0	194. 04
194.05 07955 WELLNESS CENT	ER	0	27, 606	27, 60	6 -26, 577	1, 029	194. 05
194.06 07956 PHYSICIAN PRA	CTICE CLINICS	0	0		0 0	0	194. 06
194. 07 07957 PERINATAL CLI	NI C	0	0		0 0	0	194. 07
194.08 07958 RENTAL PROPER	TY	0	3, 028, 173	3, 028, 17	3 -1, 659, 665	1, 368, 508	194. 08
194. 09 07959 ADVERTI SI NG		0	0		0	0	194. 09
194.10 07960 INTEGRA LTAC		0	0		0	0	194. 10
194. 11 07961 IU HEALTH HOS	PICE	0	0		0	0	194. 11
194.12 07962 POB MEDICAL P	AVILLION CONDOS	0	0		0	0	194. 12
194. 13 07963 PEDIATRIC THE	RAPI ES	0	0		203, 027	-203, 027	194. 13
194.14 07964 NEW CASTLE ON	COLOGY	0	0		0	0	194. 14
194. 15 07965 MARKETI NG/PUB	LIC RELATIONS	0	0		0	0	194. 15
194. 16 07966 JAY COUNTY HO	SPI TAL	0	0		1, 033, 038	1, 033, 038	194. 16
194. 17 07967 CARDI NAL HEAL	TH CHOICE	0	0		0	0	194. 17
194. 18 07968 CHV CARDI NAL	HEALTH VENTURES	0	0		0	0	194. 18
194. 19 07969 HEALTH CARE C	ONNECTI ONS	0	0		0	0	194. 19
194.20 07970 MEALS ON WHEE	LS	0	0	1	0	0	194. 20
194. 21 07971 ST MARY'S SCH		O	0		0	0	194. 21
194. 22 07972 THERAPI ES TO	OTHER ENTITIES	1, 024, 409	368, 864	1, 393, 27	3 -190, 936	1, 202, 337	194. 22
194. 23 07973 CANCER CENTER	BOUTI QUE	16, 900	72, 352	89, 25		80, 160	194. 23
194. 24 07974 BOSC BALL OUT	PATI ENT SURGERY	0	0	1	0 0	0	194. 24
194. 25 07975 CARDI NAL BEHA		450	55	50!	5 -21	484	194. 25
194. 26 07976 BLACKFORD COM	MUNITY HOSPITAL	O	274, 386	274, 38	6 495, 640	770, 026	194. 26
194. 27 07977 MI DWEST HEALT		o	0		0	•	194, 27
194. 28 07978 CARDI NAL SELE		o	0		0	0	194. 28
194. 29 07979 HOME OFFICE C		o	0		0		194, 29
194. 30 07980 CARDI NAL HEAL		ol	0		o o		194. 30
194. 31 07986 OTHER NONREIM		ol	0		o		194. 31
194. 32 07982 RENAL DI ALYSI		ol	0		0		194. 32
194. 33 07983 LAB CORP		ol	0		0		194. 33
	S MCMT	ام	_	1	ما ما		194. 34
194. 34 07984 H. O. MATERI AL	3 IVIGIVI I	UI	Ü		J U	0	1194. 34
194.34 07984 H.O. MATERIAL 194.35 07985 LEASED SPACE	3 WGWT	0	0				194. 34

near tr	n Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu of Form CM	MS-2552-1
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN:	15-0089	Peri od: Worksheet	A
					From 01/01/2023 To 12/31/2023 Date/Time	Prepared:
		1	 N		5/24/2024	9: 2 <mark>1 am</mark>
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
		6. 00	7.00			
	GENERAL SERVICE COST CENTERS	•				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	3, 560, 617	1			1.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	1			3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 499, 856				4.00
5. 01	01160 COMMUNI CATI ONS	-33, 562	735, 910			5. 01
5.02	00550 DATA PROCESSING	18, 810, 357				5. 02
5. 04 5. 05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	11, 569, 155 11, 502, 487				5. 04 5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL	-64, 756, 071	39, 341, 481			5. 06
6.00	00600 MAI NTENANCE & REPAIRS	-261, 290				6. 00
7. 00	00700 OPERATION OF PLANT	-4, 436	1			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 314, 072			8.00
9.00	00900 HOUSEKEEPI NG	-146, 836	1			9.00
10.00	01000 DI ETARY	-211, 351	2, 703, 292			10.00
11.00	01100 CAFETERI A	0				11. 00
13.00	01300 NURSING ADMINISTRATION	-300, 101	5, 266, 808			13.00
14.00		0				14. 00
15. 00	1	-441, 855	1			15. 00
16.00	+ +	0	0			16.00
18.00	+ +	-13, 875	l			18. 00
21.00	+ +	71 114	4, 864, 011			21.00
22. 00 23. 00	+ +	-71, 116 0	l			22.00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0	250, 051			23.00
30. 00		-9, 266, 840	48, 877, 730			30.00
31. 00		-15,000	1			31.00
32. 00	+ I	0	0			32.00
35.00	1 1	-1, 446, 909	2, 721, 957			35.00
40.00	04000 SUBPROVI DER - I PF	0	O			40.00
41.00	04100 SUBPROVI DER - I RF	0	2, 312, 710			41.00
43.00		0	618, 280			43.00
	ANCILLARY SERVICE COST CENTERS					
50.00		-9, 444, 161				50.00
51.00		0	2, 612, 243			51.00
52. 00 54. 00	1	-2, 051 -513, 752	4, 819, 212 13, 398, 743			52. 00 54. 00
57. 00		-513, 752	1			57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0				58. 00
59. 00		-306	1			59.00
60.00	06000 LABORATORY	-6, 440				60.00
60. 01	06001 BLOOD LABORATORY	0	1			60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	1, 471, 401			63.00
65.00	06500 RESPI RATORY THERAPY	-647	5, 124, 193			65.00
65. 01	+ +	-8, 400				65. 01
66. 00	1 1	-770, 740				66. 00
67.00	1 1	0				67.00
68.00	06800 SPEECH PATHOLOGY 06801 AUDI OLOGY	0	688, 668			68. 00
68. 01 69. 00		-85, 120	0 2, 319, 706			68. 01 69. 00
71.00	1 1	-83, 120	' '			71. 00
72.00		0	11, 115, 864			72.00
73. 00		o o	52, 199, 006			73.00
73. 01		-404, 783	1			73. 01
74.00	1 1	0	1, 637, 054			74.00
76.00	I I	0	0			76.00
76. 97	I I	-94, 786				76. 97
76. 98		-13, 644	1, 628, 566			76. 98
77. 00	1	0	· · · · · · · · · · · · · · · · · · ·			77. 00
78. 00		0	0			78.00
00 00	OUTPATIENT SERVICE COST CENTERS					- 00 00
90.00	1	120 524	0 E44 040			90.00
90. 01 90. 02	1 1	-438, 526 -308, 048	1			90. 01
90. 02	1 1	-308, 048				90. 02
91.00	1 1	-598, 361	13, 771, 525			91. 00
92. 00	1 1	3,0,001	,, 525			92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	1, 165, 070			92. 01
	OTHER REIMBURSABLE COST CENTERS	<u> </u>				
	09500 AMBULANCE SERVI CES	0	1			95. 00
102.0	10200 OPI OI D TREATMENT PROGRAM	0	0			102. 00
	SPECIAL PURPOSE COST CENTERS	_				
	D 11300 INTEREST EXPENSE	0	0			113. 00
113.0	SUBTOTALS (SUM OF LINES 1 through 117)	-46, 752, 206	466, 367, 622			118.00

 Health Financial
 Systems
 BALL MEMORE

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

Provider CCN: 15-0089

			10 12.	/31/2023 Date/11me Prep 5/24/2024 9:21	
Cost Center Description	Adjustments	Net Expenses	•		
	(See A-8)	For Allocation			
	6. 00	7. 00			
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	738, 398			190. 00
191. 00 19100 RESEARCH	0	815, 664			191. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0			194. 00
194.01 07951 BSU_PHARMACY	0	0			194. 01
194.02 07952 PAVILLION PHARMACY	0	0			194. 02
194. 03 07953 VENDI NG	0	0			194. 03
194. 04 07954 CARELI NE	0	0			194. 04
194.05 07955 WELLNESS CENTER	0	1, 029			194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	0	0			194. 06
194. 07 07957 PERINATAL CLINIC	0	0			194. 07
194. 08 07958 RENTAL PROPERTY	0	1, 368, 508			194. 08
194. 09 07959 ADVERTI SI NG	0	0		•	194. 09
194. 10 07960 I NTEGRA LTAC	0	0			194. 10
194. 11 07961 I U HEALTH HOSPICE	0	0			194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0			194. 12
194. 13 07963 PEDI ATRI C THERAPI ES	0	-203, 027			194. 13
194.14 07964 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	0	1, 033, 038			194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0			194. 17
194. 18 07968 CHV CARDI NAL HEALTH VENTURES	0	0			194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0			194. 19
194.20 07970 MEALS ON WHEELS	0	0			194. 20
194.21 07971 ST MARY'S SCHOOL	0	0			194. 21
194.22 07972 THERAPIES TO OTHER ENTITIES	-833, 472	368, 865			194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	0	80, 160			194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0			194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	484			194. 25
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	0	770, 026			194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	0			194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0			194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0		•	194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0			194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0			194. 31
194. 32 07982 RENAL DIALYSIS	0	0			194. 32
194. 33 07983 LAB CORP	0	0			194. 33
194.34 07984 H.O. MATERIALS MGMT	0	0			194. 34
194. 35 07985 LEASED SPACE	0	0			194. 35
200.00 TOTAL (SUM OF LINES 118 through 199)	-47, 585, 678	471, 340, 767		ļ	200. 00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 9:21 am

		Increases			5/24/2024 9:2	21 am
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4.00	5. 00		
	A - NON-BILLABLE SUPPLIES	0.00		0.00		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	11, 233, 912		1.00
2.00	NEW CAP REL COSTS-BLDG &	1.00	o	89		2. 00
	FLXT					
3.00	COMMUNI CATI ONS	5. 01	0	63		3. 00
4.00	ADMI TTI NG	5. 04	0	472		4. 00
5. 00	OTHER ADMINISTRATIVE AND	5. 06	0	1, 720		5. 00
	GENERAL	7 00		4.0		, 00
6.00	OPERATION OF PLANT	7.00	0	10		6.00
7.00	HOUSEKEEPI NG	9.00	0	2, 078		7. 00
8.00	DI ETARY	10.00	0	334		8.00
9. 00 10. 00	PATI ENT TRANSPORTATION OCCUPATIONAL THERAPY	18. 00 67. 00	o	112 178		9. 00 10. 00
11. 00	ELECTROCARDI OLOGY	69.00	ol	51, 908		11. 00
12. 00	CARDI AC REHABI LI TATI ON	76. 97	0	4, 355		12.00
13. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	o	591		13. 00
13.00	CANTEEN	1 70. 00	ŏ	371		13.00
14. 00	RESEARCH	191. 00	О	10		14. 00
15. 00	WELLNESS CENTER	194. 05	o	194		15. 00
16. 00	RENTAL PROPERTY	194. 08	o	841		16. 00
17. 00	CANCER CENTER BOUTIQUE	194. 23	o	480		17. 00
18. 00		0.00	Ö	0		18. 00
19. 00		0.00	Ö	Ö		19. 00
20. 00		0.00	O	0		20.00
21.00		0.00	o	0		21. 00
22.00		0.00	o	0		22. 00
23.00		0.00	o	0		23. 00
24.00		0.00	o	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
	0		0	11, 297, 347		
1 00	B - BILLABLE SUPPLIES	71 00	ما	12 547 (20		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	13, 546, 638		1. 00
2.00	FATTENTS	0.00	o	0		2. 00
3. 00		0.00	o	Ö		3. 00
4. 00		0.00	o	0		4. 00
5. 00		0.00	Ö	0		5. 00
6. 00		0.00	Ö	Ö		6. 00
7.00		0.00	O	0		7. 00
8.00		0.00	o	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 23. 00		0. 00 0. 00	0	0		22. 00 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	o	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	o	0		29. 00
30. 00		0.00	o	0		30.00
31. 00		0.00	o	Ö		31.00
32. 00		0.00	o	Ö		32. 00
33. 00		0.00	o	0		33. 00
34. 00		0.00	0	0		34. 00
	0 — — — — —					
		•		,		

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 9: 21 am Provider CCN: 15-0089

					5/24/2024	9: 21 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	C - IMPLANTABLE DEVICES					
1. 00	I MPL. DEV. CHARGED TO	72. 00	0	11, 115, 864		1. 00
0.00	PATI ENT	0.00				0.00
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
	0 — — — — —			11, 115, 864		
	D - BILLABLE DRUGS	<u> </u>				
1.00	PHARMACY	15. 00	0	1, 697, 582		1. 00
2.00	DRUGS CHARGED TO PATIENTS	73. 00	o	52, 199, 006		2. 00
3.00		0.00	o	0		3. 00
4. 00		0.00	ol	Ö		4. 00
5.00		0.00	ol	Ö		5. 00
6. 00		0.00	ol	Ö		6. 00
7. 00		0.00	o	Ö		7. 00
8. 00		0.00	ő	o		8. 00
9. 00		0.00	o	0		9. 00
10. 00	•	0.00	o	0		10.00
		l l				1
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	o	0		19. 00
20.00		0.00	ol	0		20. 00
21. 00		0.00	o	0		21. 00
22. 00		0.00	o	0		22. 00
23. 00		0.00	o	0		23. 00
24. 00		0.00	ő	Ö		24. 00
25. 00		0.00	o	o		25. 00
	•		0	0		
26. 00		0.00	-			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
	0		0	53, 896, 588		
	E - INTERN & RESIDENT SALARIE					
1. 00	I&R SERVICES-SALARY &	21. 00	81, 166	0		1. 00
	FRI_NGES_ APPRVD	+				
	0		81, 166	0		
	F - CAFETERIA					
1. 00	CAFETERI A	<u>11.</u> 00	83 <u>7, 1</u> 09	36 <u>5, 5</u> 71		1. 00
	0		837, 109	365, 571		
	G - PHARMACY ADMIN COSTS					
1.00	PAVILLION PHARMACY	194. 02	43, 109	19, 906		1. 00
	o		43, 109	19, 906		
	H - AUTO & BUILDING INSURANCE	,				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	522, 564		1. 00
	FLXT			·		
2.00		0.00	o	0		2. 00
				522, 564		
	I - REHAB ADMIN COSTS			, ,		
1.00	OCCUPATI ONAL THERAPY	67.00	72, 161	8, 570		1. 00
2. 00	SPEECH PATHOLOGY	68. 00	45, 903	5, 316		2.00
3.00	PEDI ATRI C THERAPI ES	194. 13	65, 364	7, 216		3.00
						1
4. 00	THERAPIES TO OTHER ENTITIES	194. 22	85, 391	<u>9, 310</u>		4. 00
	U L ALINDDV		268, 819	30, 412		
	J - LAUNDRY			4 02		
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	1, 314, 072		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	O	0		7. 00
	· •	<u>'</u>	<u>'</u>			·

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 9:21 am

		Increases			5/24/2024 9: 3	21 am
	Cost Center	Increases Line #	Salary	Other		
	2.00	3. 00	4.00	5. 00		
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10.00
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 16. 00		0. 00 0. 00	0	0		15. 00 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 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	0	0		22.00
23. 00		0.00	Ö	Ö		23. 00
24.00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00			0	0 1,314,072		26. 00
	L - IRF AND PACU MEDSURG		<u> </u>	1,011,072		1
1.00	ADULTS & PEDIATRICS	30.00	817, 577	84, 546		1. 00
2.00		0.00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	0	0		5. 00
	0		817, 577	84, 546]
1 00	Q - NURSERY NURSERY	43.00	F02 07/	11/ 20/		1 00
1. 00 2. 00	NURSERY	0.00	502, 076 0	116, 204 0		1. 00 2. 00
	0 — — — — —		502, 076	116, 204]
1 00	S - EMPLOYEE BENEFITS	4 00		05 000 777		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	25, 838, 777 0		1. 00 2. 00
3.00		0.00	0	o		3. 00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	Ö	Ö		8.00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	Ö	Ö		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	0	O		18. 00
19. 00		0.00	0	0		19. 00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	Ö	Ö		28. 00
29. 00		0.00	0	0		29. 00
30.00		0. 00 0. 00	0	0		30.00
31. 00 32. 00		0.00	0	0		31. 00 32. 00
33. 00		0.00	0	o		33. 00
34.00		0.00	0	0		34.00
35. 00		0.00	0	0		35.00
36. 00 37. 00		0. 00 0. 00	0	0		36. 00 37. 00
38. 00		0.00	0	o		38. 00
39. 00		0.00	0	0		39. 00
40.00		0.00	0	0		40.00
41. 00 42. 00		0. 00 0. 00	0	0		41. 00 42. 00
00	1	3.00	9	٥		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 9:21 am Provider CCN: 15-0089

					/24/2024 9: 21 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
43. 00	2. 00	3.00	4.00	5.00	 43. 00
44. 00		0.00	0	0	44. 00
00			<u> </u>		1.1.00
	T - CORPORATE TELEHPONE				
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	778	1. 00
2. 00	GENERAL	0.00	0	o	2. 00
3.00		0.00	0	0	3. 00
4. 00		0.00	0	Ö	4. 00
	U - DEPRECIATION				
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	23, 239, 447	1. 00
2. 00	FIXT	0.00	0	o	2. 00
3.00		0.00	0		3. 00
4. 00		0.00	0		4. 00
5.00		0.00	0		5. 00
6.00		0.00	0		6. 00
7. 00		0. 00	0		7. 00
8.00		0.00	0		8. 00
9. 00 10. 00		0. 00 0. 00	0		9. 00 10. 00
11. 00		0.00	0		11. 00
12. 00		0.00	0		12. 00
13. 00		0.00	0		13. 00
14.00		0.00	0		14. 00
15.00		0.00	0		15. 00
16. 00		0. 00	0		16. 00
17. 00		0.00	0		17. 00
18. 00 19. 00		0. 00 0. 00	0		18.00
20. 00		0.00	0		19. 00 20. 00
21. 00		0.00	0		21. 00
22. 00		0.00	0		22. 00
23.00		0.00	0		23. 00
24.00		0.00	0		24. 00
25. 00		0.00	0		25. 00
26. 00		0.00	0		26. 00
27. 00 28. 00		0. 00 0. 00	0		27. 00 28. 00
29. 00		0.00	0		29. 00
30.00		0.00	0		30.00
31.00		0.00	0		31.00
32.00		0.00	0		32. 00
33. 00		0.00	0		33. 00
34. 00		0. 00 0. 00	0		34. 00 35. 00
35. 00 36. 00		0.00	0		36. 00
37. 00		0.00	0		37. 00
07.00		— — - 	$ \frac{1}{0}$		07.00
	V - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	465, 315	1. 00
2. 00	FIXT	0.00	0	o	2. 00
3.00		0.00	0		3. 00
0.00		— — - 	— — <u> </u>		0.00
	W - PTO USED AS STD			·	
1.00	COMMUNI CATI ONS	5. 01	0	,	1. 00
2.00	ADMITTING	5. 04	0		2.00
3. 00	OTHER ADMINISTRATIVE AND	5. 06	0	14, 332	3. 00
4. 00	GENERAL MAINTENANCE & REPAIRS	6. 00	0	1, 414	4. 00
5. 00	OPERATION OF PLANT	7. 00	0		5. 00
6. 00	HOUSEKEEPI NG	9. 00	O		6. 00
7.00	DI ETARY	10. 00	0	26, 377	7. 00
8. 00	NURSING ADMINISTRATION	13. 00	0		8. 00
9.00	PHARMACY	15.00	0	28, 861	9.00
10.00	PATIENT TRANSPORTATION	18.00	0		10.00
11. 00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22. 00	0	331	11. 00
12. 00	ADULTS & PEDIATRICS	30.00	0	139, 010	12. 00
13. 00	INTENSIVE CARE UNIT	31.00	Ö		13. 00
14. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	29, 005	14. 00
15. 00	SUBPROVI DER - I RF	41.00	0	5, 787	15. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/24/2024 9: 21 am Provider CCN: 15-0089

					5/24/2024	9: 21 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
1/ 00	2.00	3.00	4. 00	5. 00		1/ 00
16.00	OPERATING ROOM RECOVERY ROOM	50.00	0			16.00
17. 00 18. 00	DELIVERY ROOM & LABOR ROOM	51. 00 52. 00	0			17. 00 18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	,		19. 00
20. 00	CT SCAN	57.00	0			20.00
21. 00	CARDIAC CATHETERIZATION	59.00	0			21. 00
22. 00	RESPIRATORY THERAPY	65. 00	0			22. 00
23. 00	PHYSI CAL THERAPY	66.00	0			23. 00
24.00	OCCUPATI ONAL THERAPY	67.00	0	2, 267		24. 00
25.00	SPEECH PATHOLOGY	68.00	0	10, 836		25. 00
26.00	ELECTROCARDI OLOGY	69. 00	0			26. 00
27. 00	HOSPITAL BASED RETAIL	73. 01	0	3, 732		27. 00
	PHARMACI ES			0.74		
28. 00	SUBSTANCE ABUSE CLINIC	90. 01	0			28. 00
29. 00	ONCOLOGY CLINIC	90. 03 91. 00	0			29. 00
30. 00 31. 00	EMERGENCY OBSERVATION BEDS (DISTINCT	91.00	0	66, 746 8, 090		30. 00 31. 00
31.00	PART)	92.01	Ü	8,090		31.00
32. 00	RESEARCH	191. 00	0	1, 215		32. 00
33. 00	PAVILLION PHARMACY	194. 02	0			33. 00
			<u> </u>	605, 090		
	X - WASTE DI SPOSAL					
1.00	OPERATION OF PLANT	7. 00	0	686, 725		1. 00
2.00		0. 00	0			2. 00
3.00		0. 00	0			3. 00
4.00		0.00	0			4. 00
5.00		0.00	0			5. 00
6.00		0.00	0			6.00
7.00		0.00	0	-		7. 00
8. 00 9. 00		0. 00 0. 00	0			8. 00 9. 00
10. 00		0.00	0			10.00
11. 00		0.00	0			11.00
12. 00		0.00	0			12. 00
13. 00		0.00	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	L	0.00	0			17. 00
	0		0	686, 725		
	Y - UTILITIES	= aal				
1.00	OPERATION OF PLANT	7. 00 66. 00	0			1.00
2. 00 3. 00	PHYSI CAL THERAPY	0.00	0			2. 00 3. 00
4.00		0.00	0			4. 00
5. 00		0.00	0			5. 00
6. 00		0.00	0			6. 00
7.00		0.00	0			7. 00
8.00		0.00	0			8. 00
	0			5, 654, 447		
	Z - BLACKFORD					
1.00	BLACKFORD COMMUNITY HOSPITAL	194. 26	550, 400			1. 00
2.00		0. 00	0	1		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 7. 00		0. 00 0. 00	0	0		6. 00 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		000	0	0		12. 00
	0		550, 400	162, 705		
	AA - INTEREST EXPENSE			1		
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	74		1. 00
	FIXT — — — —	+	— — <u> </u>	<u> </u>		
	O AB - PARAMEDICAL EDUCATION		0	74		
1. 00	PARAMED ED PRGM	23.00	139, 338	10, 659		1.00
1.00	0		139, 338			1.00
	ı- I	ı	107, 000	10,007		į.

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS BALL MEMORIAL HOSPITAL Provider CCN: 15-0089

						o 12/31/2023	Date/Time Prepared: 5/24/2024 9:21 am
	Increases						
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4.00	5. 00			
	AC - PROPERTY TAX	<u> </u>	<u> </u>				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	234, 875			1. 00
	FIXT						
2.00		0.00	0	0			2. 00
	0			234, 875			
	AD - JAY HOSPITAL						
1.00	JAY COUNTY HOSPITAL	194. 16	788, 110	244, 928			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	O	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	O	0			10.00
11. 00		0.00	o	0			11.00
			788, 110	244, 928			
	AE - MALPRACTICE INSURANCE						
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	550			1.00
	GENERAL						
	0		0	550			
	AH - CONTRACTED I&R						
1.00	I&R SERVICES-SALARY &	21. 00	0	4, 782, 845			1.00
	FRI NGES APPRVD						
	TOTALS		0	4, 782, 845			
	AI - PHYSICIANS						
1.00	ADULTS & PEDIATRICS	30. 00	77 <u>6, 7</u> 79	<u>1, 352, 3</u> 13			1.00
	TOTALS		776, 779	1, 352, 313			
	AJ - PAVILLION PHARMACY-RETAI						
1.00	HOSPITAL BASED RETAIL	73. 01	1, 095, 928	9, 312, 914			1. 00
	PHARMACI ES		+				
	TOTALS		1, 095, 928	9, 312, 914			
500.00	Grand Total: Increases		5, 900, 411	164, 902, 154			500. 00

RECLASSI FI CATIONS

Provider CCN: 15-0089

Period: Worksheet A-6 From 01/01/2023

12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - NON-BILLABLE SUPPLIES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1, 293 0 1.00 0 MAINTENANCE & REPAIRS 6.00 74, 454 14 2.00 2.00 1, 794 NURSING ADMINISTRATION 13.00 0 0 3.00 3.00 4.00 PHARMACY 15.00 0 91, 750 0 4.00 I&R SERVICES-OTHER PRGM o 0 5.00 22.00 18, 156 5.00 COSTS APPRVD 6.00 ADULTS & PEDIATRICS 30.00 o 1, 443, 745 0 6.00 INTENSIVE CARE UNIT 7.00 31.00 0 466, 573 0 7.00 8.00 NEONATAL INTENSIVE CARE UNIT 35.00 0 95, 320 0 8.00 9.00 SUBPROVIDER - IRF 41.00 0 31, 377 0 9.00 10.00 OPERATING ROOM 0 0 50.00 5, 790, 325 10 00 11.00 RECOVERY ROOM 51.00 0 72, 047 0 11.00 12.00 DELIVERY ROOM & LABOR ROOM 52.00 0 166, 379 0 12.00 0 0 13.00 RADI OLOGY-DI AGNOSTI C 54.00 729, 566 13.00 CT SCAN 0 14.00 57.00 32, 810 14.00 15.00 CARDIAC CATHETERIZATION 59.00 0 772, 578 0 15.00 o 0 16.00 LABORATORY 60.00 78 16.00 0 0 RESPIRATORY THERAPY 65.00 504.950 17.00 17.00 0 18 00 SLEEP LAB 65.01 0 43.798 18 00 19.00 PHYSICAL THERAPY 0 16,840 0 19.00 66.00 0 20.00 SPEECH PATHOLOGY 68.00 0 29 20.00 HOSPITAL BASED RETAIL 21.00 73.01 0 196 0 21.00 PHARMACI ES 22.00 RENAL DIALYSIS 74.00 0 5, 963 0 22.00 23.00 HYPERBARIC OXYGEN THERAPY 76.98 0 205, 227 0 23.00 0 24 00 SUBSTANCE ABUSE CLINIC 90.01 0 24 00 959 0 25.00 PAIN CLINIC 90.02 0 18,628 25, 00 ONCOLOGY CLINIC 90.03 0 98, 837 0 26.00 26.00 0 27.00 **EMERGENCY** 91.00 0 592, 948 27.00 OBSERVATION BEDS (DISTINCT 92.01 0 0 28.00 28.00 12, 778 PART) 29.00 PAVILLION PHARMACY 194.02 0 1,821 0 29 00 PEDIATRIC THERAPIES 30.00 194.13 6, 128 0 30.00 11, 297, 347 BILLABLE SUPPLIES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 82 0 1.00 0 0 2.00 ADMITTING 5.04 5 2.00 MAINTENANCE & REPAIRS 6.00 3.00 0 0 3.00 0 4.00 DI ETARY 10.00 0 25 4.00 5.00 NURSING ADMINISTRATION 13.00 0 371 0 5.00 CENTRAL SERVICES & SUPPLY 0 13, 632 0 6.00 14.00 6.00 0 7.00 PHARMACY 15.00 0 6,738 7 00 8.00 ADULTS & PEDIATRICS 30.00 0 315, 245 0 8.00 9.00 INTENSIVE CARE UNIT 31.00 o 96, 741 0 9.00 0 NEONATAL INTENSIVE CARE UNIT o 10.00 10.00 35.00 6.348 0 SUBPROVIDER - IRF 0 11.00 41.00 13, 543 11.00 12.00 OPERATING ROOM 50.00 0 4, 362, 493 0 12.00 0 13.00 RECOVERY ROOM 51.00 0 5, 581 13.00 DELIVERY ROOM & LABOR ROOM 0 113 959 0 14 00 52 00 14 00 0 15.00 RADI OLOGY-DI AGNOSTI C 54.00 0 1, 937, 986 15.00 57.00 o 9, 478 0 16.00 16.00 CT SCAN 6, 276, 512 17.00 CARDIAC CATHETERIZATION 59.00 0 0 17.00 RESPIRATORY THERAPY o 0 18 00 65 00 19 18 00 19.00 SLEEP LAB 65.01 0 157 0 19.00 PHYSICAL THERAPY 66.00 o 0 20.00 14, 529 20.00 0 21.00 OCCUPATIONAL THERAPY 67.00 0 243 21.00 ELECTROCARDI OLOGY 0 0 22 00 69.00 762 22 00 23.00 HOSPITAL BASED RETAIL 73.01 0 27 0 23.00 PHARMACI ES 24.00 RENAL DIALYSIS 74.00 o 13, 231 0 24.00 0 CARDIAC REHABILITATION 76.97 0 25, 00 98 25, 00 26.00 HYPERBARIC OXYGEN THERAPY 76.98 0 191, 142 0 26.00 SUBSTANCE ABUSE CLINIC 90. 01 0 0 27.00 72 27.00 0 28.00 PAIN CLINIC 90.02 o 76 28.00 loncology clinic 0 11, 276 0 29 00 90.03 29 00 30.00 EMERGENCY 91.00 0 153, 869 0 30.00 OBSERVATION BEDS (DISTINCT 0 31.00 92.01 2,042 31.00 PART) PAVILLION PHARMACY 194 02 0 0 32 00 285 32 00 33.00 PEDIATRIC THERAPIES 194.13 0 65 0 33.00 34.00 CARDINAL BEHAVIORAL HEALTH 194. 25 0 34.00

o

13, 546, 638

	CLELCATIONS		DALL WEWORTA		20N 1F 0000		W
RECLAS	SI FI CATI ONS			Provider C		Peri od: From 01/01/2023	Worksheet A-6
							Date/Time Prepared:
							5/24/2024 9:21 am
		Decreases				1	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	C - IMPLANTABLE DEVICES				1		
1. 00	ADULTS & PEDIATRICS	30.00	0	68		O	1. 00
2.00	INTENSIVE CARE UNIT	31. 00	0	424		O	2. 00
3.00	OPERATING ROOM	50. 00	0	6, 302, 786		O	3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	53, 746		O	4. 00
5.00	CARDIAC CATHETERIZATION	59. 00	0	4, 729, 201		O	5. 00
6. 00	RESPI RATORY THERAPY	65. 00	0	12		O	6. 00
7. 00	SPEECH PATHOLOGY	68. 00	0	303		O	7. 00
8.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	27, 000		O	8. 00
9.00	PAIN CLINIC	90. 02	0	2, 280		O	9. 00
10. 00	EMERGENCY	<u>91.</u> 00	•	44		<u> </u>	10. 00
	0		0	11, 115, 864			
	D - BILLABLE DRUGS				1		
1. 00	PHARMACY	15. 00	0	49, 508, 154		O	1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	94, 533		O	2. 00
3.00	ADMI TTI NG	5. 04	0	14		O	3. 00
4.00	MAINTENANCE & REPAIRS	6.00	0	186		0	4.00
5.00	NURSING ADMINISTRATION	13. 00	0	2, 780		0	5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	2, 466		0	6. 00
7. 00	I&R SERVICES-OTHER PRGM	22. 00	0	29, 814	(0	7. 00
0.00	COSTS APPRVD		إ	475			
8.00	ADULTS & PEDIATRICS	30.00	0	475, 448		0	8. 00
9.00	INTENSIVE CARE UNIT	31.00	0	272, 914		0	9.00
10.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	19, 612		0	10.00
11.00	SUBPROVI DER – I RF	41. 00	0	4, 620		0	11.00
12.00	OPERATING ROOM	50.00	0	377, 157		0	12.00
13.00	RECOVERY ROOM	51.00	0	108, 546		0	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	66, 073		0	14. 00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 398, 066		0	15. 00
16.00	CT SCAN	57. 00	0	416, 102		0	16. 00
17. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	164, 311		0	17. 00
18.00	RESPIRATORY THERAPY	65. 00	0	15, 928		0	18. 00
19.00	SLEEP LAB	65. 01	0	75		0	19. 00
20.00	PHYSI CAL THERAPY	66.00	0	78		0	20.00
21. 00	ELECTROCARDI OLOGY	69. 00	0	221, 938		0	21. 00
22. 00	RENAL DIALYSIS	74. 00	0	8, 439		0	22. 00
23. 00	CARDI AC REHABI LI TATI ON	76. 97	0	5		0	23. 00
24. 00	HYPERBARI C OXYGEN THERAPY	76. 98	0	66, 433		0	24. 00
25. 00	PAIN CLINIC	90. 02	0	3, 355		0	25. 00
26. 00	ONCOLOGY CLINIC	90. 03	0	108, 131		0	26. 00
27. 00	EMERGENCY	91.00	0	514, 865		0	27. 00
28. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	13, 009	1	O	28. 00
20.00	PART)	104 00		2 504			29. 00
29. 00	PAVILLION PHARMACY	194. 02	0	3, 506		0	
30. 00	PEDI ATRI C THERAPI ES	194.13	}	30		<u> </u>	30.00
	E INTERN & DECIDENT SALARIE	·c	0	53, 896, 588			
1. 00	E - INTERN & RESIDENT SALARIE	22. 00	81, 166				1.00
1.00	COSTS APPRVD	22.00	01, 100	U	1		1.00
	0 APPRVD	— — — +	81, 166	— — <u> </u>		+	ł
	F - CAFETERIA		01, 100				
1.00	DI ETARY	10.00	837, 109	365, 571		O O	1. 00
1.00	0		837, 109	365, 571		<u> </u>	1.00
	G - PHARMACY ADMIN COSTS		037, 107	303, 371			
1.00	HOSPITAL BASED RETAIL	73. 01	43, 109	19, 906	1		1. 00
1.00	PHARMACI ES	73.01	43, 107	17, 700	`		1.00
	0		43, 109	19, 906		†	
	H - AUTO & BUILDING INSURANCE		10, 107	17, 700			
1.00	OTHER ADMINISTRATIVE AND	5. 06	n	521, 280	1:	2	1. 00
1.00	GENERAL	0.00	Ĭ	021, 200		-	1. 00
2.00	RENTAL PROPERTY	194. 08	0	1, 284		0	2. 00
	0	— — ; , , , , , , , , , , , , , , , , , , 	— — <u> </u>	522, 564		1	2.33
	I - REHAB ADMIN COSTS		3			<u> </u>	
1.00	PHYSI CAL THERAPY	66.00	268, 819	30, 412	(O	1.00
2. 00	1 1 1 1 1 1 1	0.00		۵۵, ۱۱۷			2.00
3. 00		0.00	ő	n		o o	3. 00
4.00		0.00	ol	0			4. 00
			268, 819	30, 412		7	
	J - LAUNDRY	<u>'</u>		·			

400 141 596, 880

6, 869

0 0 0

0 0 0

1. 00 2. 00

3. 00 4. 00

U
J - LAUNDRY

ADMITTING

HOUSEKEEPING

CENTRAL SERVICES & SUPPLY
PHARMACY

5. 04 9. 00 14. 00

15.00

1.00

2.00

3.00 4.00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 9: 21 am

						5/24/2024 9:	21 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
F 00	6. 00	7. 00	8. 00	9.00	10.00	,	F 00
5.00	I&R SERVICES-OTHER PRGM	22. 00	0	28	0		5. 00
6. 00	COSTS APPRVD ADULTS & PEDIATRICS	30.00	o	327, 457	o		6. 00
7. 00	INTENSIVE CARE UNIT	31. 00	0	75, 483	o		7. 00
8. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	11, 536	0		8. 00
9. 00	SUBPROVI DER - I RF	41. 00	0	21, 663	o		9. 00
10. 00	OPERATING ROOM	50.00	0	77, 880	o		10.00
11. 00	RECOVERY ROOM	51.00	0	21, 719	o o		11. 00
12. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	29, 331	o o		12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54. 00	O	52, 998	o		13. 00
14. 00	CARDIAC CATHETERIZATION	59.00	0	8, 153	o		14. 00
15. 00	LABORATORY	60.00	0	15	o		15. 00
16. 00	RESPIRATORY THERAPY	65.00	O	113	o		16. 00
17. 00	PHYSI CAL THERAPY	66.00	0	21, 043	o		17. 00
18. 00	ELECTROCARDI OLOGY	69.00	0	6, 766	ol		18. 00
19. 00	RENAL DIALYSIS	74. 00	o	1, 369	o		19. 00
20.00	CARDIAC REHABILITATION	76. 97	o	196	o		20. 00
21. 00	PAIN CLINIC	90. 02	o	1, 234	o		21. 00
22. 00	ONCOLOGY CLINIC	90. 03	O	12, 593	o		22. 00
23.00	EMERGENCY	91.00	O	30, 221	o		23. 00
24.00	OBSERVATION BEDS (DISTINCT	92. 01	O	3, 189	o		24. 00
	PART)						
25.00	WELLNESS CENTER	194. 05	0	5, 546	o		25. 00
26.00	PEDIATRIC THERAPIES	194. 13	0	1, 249	o		26. 00
	0 — — — — — —			1, 314, 072			
	L - IRF AND PACU MEDSURG						
1.00	NURSING ADMINISTRATION	13. 00	789, 271	79, 359	0		1. 00
2.00	SUBPROVI DER - I RF	41. 00	13, 600	2, 262	0		2. 00
3.00	RECOVERY ROOM	51.00	1, 416	168	0		3. 00
4.00	CARDIAC CATHETERIZATION	59. 00	2, 289	394	0		4. 00
5.00	OBSERVATION BEDS (DISTINCT	92. 01	11, 001	2, 363	0		5. 00
	PART)						
	0		817, 577	84, 546			_
	Q - NURSERY				_1		
1.00	ADULTS & PEDIATRICS	30.00	475, 559	95, 639			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	26, 517	20, 565	0		2. 00
	C EMPLOYEE BENEFITS		502, 076	116, 204			
1. 00	S - EMPLOYEE BENEFITS COMMUNICATIONS	5. 01	0	207, 008	0		1. 00
2.00	ADMI TTI NG	5. 04	0	620, 185	0		2. 00
3. 00	OTHER ADMINISTRATIVE AND	5. 04 5. 06	0	892, 969	0		3. 00
3.00	GENERAL	5.00	٥	072, 707	٥		3.00
4.00	MAINTENANCE & REPAIRS	6. 00	0	713, 214	ol		4. 00
5. 00	OPERATION OF PLANT	7. 00	0	265, 331	o		5. 00
6. 00	HOUSEKEEPI NG	9. 00	O	966, 643	o		6. 00
7. 00	DI ETARY	10. 00	0	619, 782	ol		7. 00
8.00	NURSING ADMINISTRATION	13. 00	o	959, 972	o		8. 00
9. 00	PHARMACY	15. 00	o	1, 081, 393			9. 00
10.00	PATIENT TRANSPORTATION	18. 00	o	344, 831	o		10. 00
11. 00	I&R SERVICES-OTHER PRGM	22. 00	o	124, 729	o		11. 00
	COSTS APPRVD						1
12.00	PARAMED ED PRGM	23. 00	O	11, 620	o		12. 00
13.00	ADULTS & PEDIATRICS	30.00	0	5, 409, 055	o		13. 00
14.00	INTENSIVE CARE UNIT	31.00	0	1, 409, 945	o		14. 00
15.00	NEONATAL INTENSIVE CARE UNIT	35.00	o	505, 962	o		15. 00
16.00	SUBPROVIDER - IRF	41. 00	0	304, 091	o		16. 00
17. 00	OPERATING ROOM	50. 00	0	1, 345, 192	O		17. 00
18.00	RECOVERY ROOM	51. 00	О	435, 363	O		18. 00
19.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	563, 000	0		19. 00
20.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 624, 558	0		20. 00
21. 00	CT SCAN	57. 00	0	216, 407	0		21. 00
22. 00	CARDIAC CATHETERIZATION	59. 00	0	472, 188	0		22. 00
23. 00	LABORATORY	60. 00	0	59	0		23. 00
24. 00	RESPIRATORY THERAPY	65. 00	0	683, 903	0		24. 00
25. 00	SLEEP LAB	65. 01	0	133, 339	0		25. 00
26. 00	PHYSI CAL THERAPY	66. 00	0	995, 801	0		26. 00
27. 00	OCCUPATI ONAL THERAPY	67. 00	0	115, 073	0		27. 00
28. 00	SPEECH PATHOLOGY	68. 00	0	123, 491	0		28. 00
29. 00	ELECTROCARDI OLOGY	69.00	0	340, 456	0		29. 00
30. 00	HOSPITAL BASED RETAIL	73. 01	0	365, 932	0		30. 00
24 00	PHARMACI ES	7, 67	_	0.45 005			21 00
31.00	CARDIAC REHABILITATION	76. 97	0	245, 085	0		31.00
32. 00 33. 00	HYPERBARIC OXYGEN THERAPY SUBSTANCE ABUSE CLINIC	76. 98 90. 01	0	159, 766	0		32. 00 33. 00
	SODSTANCE ADOSE CETNIC	90.01	٠	95, 216	ı V		1 33.00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 9:21 am

		Dooroococ				5/24/2024 9:2	Z i alli
	Cost Center	Decreases Li ne #	Sal ary	Other	 Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
34. 00	PAIN CLINIC	90. 02	0.00	92, 232			34.00
35. 00	ONCOLOGY CLINIC	90. 03	o	580, 371	1		35. 00
36. 00	EMERGENCY	91. 00	o	1, 654, 942	1		36. 00
37. 00	OBSERVATION BEDS (DISTINCT	92. 01	o	212, 062	1		37. 00
	PART)			,			
38.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	47, 973	o o		38. 00
	CANTEEN						
39.00	RESEARCH	191. 00	0	159, 579	0		39. 00
40.00	PAVILLION PHARMACY	194. 02	0	179, 048	0		40.00
41.00	PEDI ATRI C THERAPI ES	194. 13	0	268, 135	0		41. 00
42.00	THERAPIES TO OTHER ENTITIES	194. 22	0	283, 288	0		42. 00
43.00	CANCER CENTER BOUTIQUE	194. 23	0	9, 572	2 0		43. 00
44. 00	CARDINAL BEHAVIORAL HEALTH	1 <u>94.</u> 25	0	16			44. 00
	0		0	25, 838, 777	7		
	T - CORPORATE TELEHPONE						
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	131			1. 00
2. 00	ADULTS & PEDIATRICS	30.00	0	127			2. 00
3. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	338	1		3. 00
4.00	OPERATI NG ROOM	50.00	0				4. 00
	0		0	778	3		
4 00	U - DEPRECIATION	E 04	ما	00.74			1 00
1.00	ADMITTING	5. 04	0	32, 716	1		1.00
2. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	1, 072, 622	0		2. 00
3. 00	MAINTENANCE & REPAIRS	6. 00	o	5 074 405	ol ol		3. 00
3. 00 4. 00	OPERATION OF PLANT	7.00	ol Ol	5, 874, 495 88, 301	1		4. 00
5. 00	HOUSEKEEPI NG	9.00	ol	12, 396			5. 00
6. 00	DI ETARY	10.00	0	88, 153	1		6. 00
7. 00	NURSING ADMINISTRATION	13. 00	ol	1, 964, 036	1		7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	ol	22, 941	1		8.00
9. 00	PHARMACY	15. 00	ol	660, 534	1		9. 00
10. 00	PATIENT TRANSPORTATION	18. 00	o	15, 082	1		10.00
11. 00	I&R SERVICES-OTHER PRGM	22. 00	o	268, 485			11.00
11.00	COSTS APPRVD	22.00	ď	200, 400	ή		11.00
12. 00	ADULTS & PEDIATRICS	30.00	o	2, 625, 726	ol ol		12. 00
13. 00	INTENSIVE CARE UNIT	31.00	0	108, 895			13. 00
14. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	ol	399, 040	1		14. 00
15. 00	SUBPROVI DER - I RF	41. 00	o	21, 643			15. 00
16. 00	OPERATING ROOM	50.00	o	2, 767, 590			16. 00
17. 00	RECOVERY ROOM	51. 00	o	201, 378			17. 00
18. 00	DELIVERY ROOM & LABOR ROOM	52. 00	o	1, 808, 548	1		18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	1, 536, 949			19. 00
20. 00	CT SCAN	57. 00	o	94, 690	1		20.00
21. 00	CARDIAC CATHETERIZATION	59. 00	o	347, 925			21. 00
	RESPI RATORY THERAPY	65. 00	o	175, 101			22. 00
23. 00	SLEEP LAB	65. 01	o	965	1		23. 00
24. 00	PHYSI CAL THERAPY	66.00	o	120, 970	1		24. 00
25.00	OCCUPATI ONAL THERAPY	67. 00	0	600	1		25. 00
26.00	ELECTROCARDI OLOGY	69. 00	0	386, 084	ı o		26. 00
27.00	RENAL DIALYSIS	74.00	0	7, 664			27. 00
28. 00	CARDIAC REHABILITATION	76. 97	0	38, 050	o		28. 00
29. 00	HYPERBARIC OXYGEN THERAPY	76. 98	0	15, 410	o		29. 00
30.00	PAIN CLINIC	90. 02	0	34, 523	0		30.00
31.00	ONCOLOGY CLINIC	90. 03	0	663, 488	0		31.00
32.00	EMERGENCY	91.00	O	503, 016	0		32. 00
33.00	OBSERVATION BEDS (DISTINCT	92. 01	o	25, 655	0		33. 00
	PART)						
34.00	WELLNESS CENTER	194. 05	O	21, 225	1		34. 00
35.00	RENTAL PROPERTY	194. 08	0	1, 094, 421			35. 00
36.00	THERAPIES TO OTHER ENTITIES	194. 22	0	2, 349	0		36. 00
37.00	BLACKFORD COMMUNITY HOSPITAL	1 <u>94.</u> 26	0	13 <u>7, 7</u> 81			37. 00
	0		0	23, 239, 447	7		
	V - LEASE EXPENSE						
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	220, 223	1		1. 00
2.00	ONCOLOGY CLINIC	90. 03	0	172, 616			2. 00
3.00	RENTAL PROPERTY	1 <u>94.</u> 08	0	7 <u>2, 4</u> 76			3. 00
	0		0	465, 315	5		
	W - PTO USED AS STD						
1.00	COMMUNI CATI ONS	5. 01	1, 296	C			1.00
2.00	ADMITTING	5. 04	12, 876	C	1 1		2.00
3. 00	OTHER ADMINISTRATIVE AND	5. 06	14, 332	C	0		3. 00
4 00	GENERAL	, 00		-	,		4 00
4.00	MAINTENANCE & REPAIRS	6.00	1, 414	C	1		4.00
5. 00	OPERATION OF PLANT	7. 00	1, 170	C	0		5.00
		_		_			

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 9: 21 am

						5/24/2024 9::	21 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
6.00	HOUSEKEEPI NG	9. 00	29, 178	0	0		6. 00
7.00	DI ETARY	10.00	26, 377	0	0		7. 00
8.00	NURSING ADMINISTRATION	13. 00	14, 116	0	0		8. 00
9.00	PHARMACY	15. 00	28, 861	0	O		9. 00
10.00	PATIENT TRANSPORTATION	18. 00	101	0	O		10.00
11.00	I&R SERVICES-OTHER PRGM	22. 00	331	0	O		11.00
	COSTS APPRVD						
12.00	ADULTS & PEDIATRICS	30.00	139, 010	0	O		12.00
13.00	INTENSIVE CARE UNIT	31.00	28, 707	0	0		13.00
14.00	NEONATAL INTENSIVE CARE UNIT	35.00	29, 005	0	0		14.00
15.00	SUBPROVI DER - I RF	41.00	5, 787	0	O		15. 00
16. 00	OPERATING ROOM	50. 00	46, 663	0	o		16. 00
17. 00	RECOVERY ROOM	51.00	5, 407	0	0		17. 00
18. 00	DELIVERY ROOM & LABOR ROOM	52.00	36, 426	0	0		18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	47, 548	0	0		19. 00
20. 00	CT SCAN	57. 00	2, 997	0	o		20.00
21. 00	CARDIAC CATHETERIZATION	59. 00	3, 996	0	o		21. 00
22. 00	RESPIRATORY THERAPY	65. 00	4, 960	0	o		22. 00
23. 00	PHYSI CAL THERAPY	66.00	28, 109	0	o		23. 00
24. 00	OCCUPATIONAL THERAPY	67.00	2, 267	0	o		24. 00
25. 00	SPEECH PATHOLOGY	68.00	10, 836	0	o		25. 00
26. 00	ELECTROCARDI OLOGY	69.00	290	0	o		26.00
27. 00	HOSPITAL BASED RETAIL	73. 01	3, 732	0	o		27. 00
21.00	PHARMACIES	/3.01	3, 132	U	٩		27.00
28. 00	SUBSTANCE ABUSE CLINIC	90. 01	2, 716	0	0		28. 00
29. 00	ONCOLOGY CLINIC	90.01	2, 718	0	0		29.00
30.00	EMERGENCY	91. 00	66, 746	0	0		30.00
31. 00	OBSERVATION BEDS (DISTINCT	91.00 92.01	8, 090	0	0		31.00
31.00	PART)	72.01	6, 090	U	٥		31.00
32. 00	RESEARCH	191. 00	1, 215	0	0		32. 00
33. 00	PAVILLION PHARMACY	194. 02	233	0	0		33. 00
33.00	O LETON FITARWACT	174.02	605, 090	— — — 0	— — — 4		33.00
	X - WASTE DI SPOSAL		003, 070	O _I			
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	75, 703	14		1.00
	FIXT		Ĭ	, 0, , 00			
2.00	OTHER ADMINISTRATIVE AND	5. 06	o	1, 317	o		2. 00
	GENERAL			, -			
3.00	MAINTENANCE & REPAIRS	6.00	0	23, 565	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	498, 234	0		4. 00
5.00	DI ETARY	10. 00	o	1, 500	o		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	o	2, 862	o		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	o	2, 375	0		7. 00
8. 00	OPERATING ROOM	50.00	o	835	o		8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	3, 857	0		9. 00
10. 00	SLEEP LAB	65. 01	o	916	o		10.00
11. 00	PHYSI CAL THERAPY	66.00	0	117	o		11. 00
12. 00	HOSPITAL BASED RETAIL	73. 01	o	4, 800	o		12. 00
	PHARMACI ES			.,	-		1
13.00	SUBSTANCE ABUSE CLINIC	90. 01	o	1, 852	o		13. 00
14.00	PAIN CLINIC	90. 02	o	18, 719	0		14. 00
15. 00	ONCOLOGY CLINIC	90. 03	o	36	o		15. 00
16. 00	RENTAL PROPERTY	194. 08	o	46, 041	o		16. 00
17. 00	BLACKFORD COMMUNITY HOSPITAL	194. 26	o	3, 996	o		17. 00
	0		$$ $\frac{1}{0}$	686, 725	— — — ¾		
	Y - UTILITIES			322, 120			1
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	313, 842	14		1. 00
	FIXT	50	٦	0, 0 . 2	. '		
2.00	OTHER ADMINISTRATIVE AND	5. 06	o	3, 309	o		2. 00
	GENERAL			.,			
3.00	MAINTENANCE & REPAIRS	6.00	0	4, 807, 391	o		3. 00
4.00	SLEEP LAB	65. 01	o	3, 215	0		4. 00
5. 00	HYPERBARIC OXYGEN THERAPY	76. 98	0	2, 408	0		5. 00
6. 00	ONCOLOGY CLINIC	90. 03	0	3, 912	o		6. 00
7. 00	RENTAL PROPERTY	194. 08	n	444, 682	o		7. 00
8. 00	BLACKFORD COMMUNITY HOSPITAL	194. 26	ol	75, 688	o		8. 00
- =	0		₀	5, 654, 447			
	Z - BLACKFORD		-1				1
1.00	OTHER ADMINISTRATIVE AND	5. 06	271, 537	79, 021	0		1. 00
	GENERAL		.	•			
2.00	MAINTENANCE & REPAIRS	6. 00	6, 415	7, 354	0		2. 00
3.00	OPERATION OF PLANT	7. 00	17, 538	6, 010	0		3. 00
4.00	DI ETARY	10. 00	4, 533	337	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	87, 757	30, 091	o		5. 00
6.00	PHARMACY	15. 00		17, 268	0		6. 00
		<u>'</u>		· · · · · ·	'		

RECLASSI FI CATIONS

Provider CCN: 15-0089

Period: Worksheet A-6 From 01/01/2023

1.00

500 00

12/31/2023 Date/Time Prepared: 5/24/2024 9:21 am Decreases Cost Center Li ne # Sal ary 0ther Wkst. A-7 Ref. 10.00 6.00 7.00 8.00 9.00 7.00 RADI OLOGY-DI AGNOSTI C 7. 00 54.00 49, 964 6, 571 0 8.00 CARDIAC CATHETERIZATION 59.00 4, 368 475 0 8.00 RESPIRATORY THERAPY 0 9.00 65.00 24, 466 13,090 9.00 10.00 PHYSI CAL THERAPY 66, 00 12, 859 1, 402 0 10.00 11.00 ELECTROCARDI OLOGY 69.00 5,862 715 0 11.00 CARDIAC REHABILITATION 76. 97 3, 774 0 12.00 12.00 371 162, 705 550, 400 AA - INTEREST EXPENSE 1.00 OTHER ADMINISTRATIVE AND 5.06 0 74 13 1.00 74 AB - PARAMEDICAL EDUCATION 1.00 PHARMACY 15.00 13<u>9, 3</u>38 10, 659 0 1.00 139, 338 10, 659 AC - PROPERTY TAX 1.00 OTHER ADMINISTRATIVE AND 5.06 0 233, 273 13 1.00 GENERAL 2.00 RENTAL PROPERTY 194.08 1,602 0 2.00 234, 875 AD - JAY HOSPITAL 1.00 OTHER ADMINISTRATIVE AND 5.06 378, 526 113, 661 0 1.00 GENERAL 2.00 MAINTENANCE & REPAIRS 6.00 12, 414 14, 231 0 2.00 3.00 OPERATION OF PLANT 7.00 17, 538 6, 010 0 3.00 DI FTARY 10.00 6, 682 497 0 4.00 4.00 0 5.00 NURSING ADMINISTRATION 13.00 161, 010 57, 107 5.00 6.00 PHARMACY 15.00 97, 556 27, 468 0 6.00 7, 309 0 RADI OLOGY-DI AGNOSTI C 54.00 56, 243 7.00 7.00 CARDIAC CATHETERIZATION 59.00 2, 922 8.00 318 8 00 9.00 RESPIRATORY THERAPY 65.00 28, 657 15, 332 0 9.00 PHYSICAL THERAPY 10.00 66.00 18, 953 2,067 0 10.00 11.00 ELECTROCARDI OLOGY <u>69.</u>00 928 0 11.00 7,609 788, 110 244, 928 - MALPRACTICE INSURANCE 1.00 I&R SERVICES-OTHER PRGM 22.00 550 0 1.00 COSTS APPRVD Ō 550 AH - CONTRACTED I&R 1.00 I&R SERVICES-OTHER PRGM 22.00 0 4, 782, 845 0 1.00 COSTS APPRVD TOTALS ō 4, 782, 845 AI - PHYSICIANS 1.00 OTHER ADMINISTRATIVE AND 5.06 776, 779 1, 352, 313 0 1.00 GENERAL 776, 779 1. 352. 313 ITOTALS AJ - PAVILLION PHARMACY-RETAIL

194.02

1, 095, 928

1, 095, 928

6, 505, 501

9, 312, 914

9, 312, 914

164, 297, 064

1.00

PAVILLION PHARMACY

500.00 Grand Total: Decreases

TOTALS

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS BALL MEMORIAL HOSPITAL

Provider CCN: 15-0089

				Γ	o 12/31/2023	Date/Time Pre 5/24/2024 9:2	
				Acqui si ti ons		072172021 712	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	6, 072, 523	0	C	0	0	1. 00
2.00	Land Improvements	3, 429, 715	0	C	0	0	2. 00
3.00	Buildings and Fixtures	281, 611, 985	6, 014	C	6, 014		3. 00
4.00	Building Improvements	111, 584, 733	24, 705, 005	C	24, 705, 005	0	4. 00
5.00	Fixed Equipment	0	0	C	0	0	5. 00
6.00	Movable Equipment	129, 945, 040	26, 720, 874	C	26, 720, 874	2, 904, 056	1
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	532, 643, 996	51, 431, 893	C	51, 431, 893	2, 904, 056	
9.00	Reconciling Items	0	0	C	0	0	9. 00
10. 00	Total (line 8 minus line 9)	532, 643, 996	51, 431, 893	C	51, 431, 893	2, 904, 056	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
		/ 00	Assets				
	DART I ANALYSIS OF CHANGES IN CARLTAL ASSET	6.00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				1. 00
		6, 072, 523	2 125 (/7				
2. 00 3. 00	Land Improvements	3, 429, 715	3, 135, 667				2. 00 3. 00
4. 00	Buildings and Fixtures	281, 617, 999	110, 585, 019				4. 00
5. 00	Building Improvements	136, 289, 738	1, 196, 984				5.00
6. 00	Fixed Equipment	153, 761, 858	84, 589, 427				6. 00
7. 00	Movable Equipment HIT designated Assets	100, 701, 808	04, 307, 427				7.00
8. 00		581, 171, 833	199, 507, 097				8.00
9. 00	Subtotal (sum of lines 1-7) Reconciling Items	001, 1/1, 000	177, 307, 097				9. 00
10. 00	Total (line 8 minus line 9)	581, 171, 833	199, 507, 097				10.00
10.00	Total (Tine o minus Tine 7)	301, 171, 033	177, 307, 097				10.00

Heal th	Financial Systems	BALL MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0089	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		nared·
					12/01/2020	5/24/2024 9: 2	
SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	338, 697	6, 006		0 0	3, 186	1. 00
3.00	Total (sum of lines 1-2)	338, 697	6, 006		0 0	3, 186	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 308, 576	1, 656, 465				1. 00
3.00	Total (sum of lines 1-2)	1, 308, 576	1, 656, 465				3. 00

Heal th	Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2023	Worksheet A-7 Part III	
				7	To 12/31/2023	Date/Time Prep 5/24/2024 9:21	
		COME	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 - col.	instructions)		
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE				_		
1.00	NEW CAP REL COSTS-BLDG & FLXT	581, 171, 833	l e			0	1. 00
3.00	Total (sum of lines 1-2)	581, 171, 833		581, 171, 833			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		6, 00	d Costs 7.00	through 7) 8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	0.00	9.00	10.00	
1. 00	NEW CAP REL COSTS-BLDG & FLXT	INIEKS	0	(46, 721, 395	471, 321	1. 00
3.00	Total (sum of lines 1-2)	0	0		46, 721, 395		3. 00
3.00	Total (sum of fiftes 1 2)		SI.	JMMARY OF CAPI		471, 321	3.00
			30	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	171 <u>L</u>		
	Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-19, 880, 705					1. 00
3.00	Total (sum of lines 1-2)	-19, 880, 705	522, 564	238, 135	1, 217, 191	29, 289, 901	3. 00

					o 12/31/2023	Date/Time Prep 5/24/2024 9:2	oared: 1 am
				Expense Classification on	Worksheet A	3/24/2024 7.2	ı dili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Investment income - NEW CAP	В	-19, 880, 705	NEW CAP REL COSTS-BLDG &	1.00	11	1. 00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	О	2. 00
2 00	COSTS-MVBLE EQUIP (chapter 2)		0		0.00		2 00
3. 00	Investment income - other (chapter 2)		Ü		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	o	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
0.00	expenses (chapter 8)		0		0.00	Ĭ	0.00
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	o	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0.00	0	8. 00
0.00	(chapter 21)		0		0.00	Ĭ	0.00
9. 00 10. 00	Parking Lot (chapter 21)	A-8-2	-21, 651, 533		0.00	0	9. 00 10. 00
10.00	Provider-based physician adjustment	A-0-2	-21, 001, 003				10.00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	55, 523, 693			0	12. 00
	transactions (chapter 10)		00,020,070				
13. 00 14. 00	Laundry and linen service	В	0	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Cafeteria-employees and guests Rental of quarters to employee	1	0	CAFETERIA	0.00		15. 00
4.00	and others						
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
40.00	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		20. 00 21. 00
21.00	interest, finance or penalty		0		0.00		21.00
00.00	charges (chapter 21)				0.00		00.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	U	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	limitation (chapter 14)						
24. 00		A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	О	26. 00
27.00	COSTS-BLDG & FLXT			FIXT	2.00		27.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		Ü	*** Cost Center Deleted ***	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 00
29. 00 30. 00	1 3	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of		0		37.00		
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & DEDIATRICS	30.00		30. 99
30. 99	instructions)		U	ADULTS & PEDIATRICS	30.00		30. 77
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 01/01/2023 Date/Time Prepared: 5/24/2024 9:21 am Provider CCN: 15-0089

				To	12/31/2023	Date/Time Prep 5/24/2024 9: 2	
				Expense Classification on		37 247 2024 7. 2	am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33.00	MI SCELLANEOUS I NCOME	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
34. 00 35. 00	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		COMMUNICATIONS OTHER ADMINISTRATIVE AND	5. 01 5. 06	0	34. 00 35. 00
33. 00	WI SCEELANEOUS THOUME			GENERAL STRATT VE AND	5.00	J	33.00
36. 00	MI SCELLANEOUS I NCOME	В	,	MAINTENANCE & REPAIRS	6. 00	0	36. 00
37. 00 38. 00	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	37. 00 38. 00
39. 00	MI SCELLANEOUS I NCOME	В	-211, 351		10.00	0	39. 00
40.00	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00	0	40. 00
41. 00	MI SCELLANEOUS I NCOME	В	-441, 855		15.00	0	41.00
42. 00 43. 00	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		PATIENT TRANSPORTATION I&R SERVICES-OTHER PRGM	18. 00 22. 00	0	42. 00 43. 00
10.00	IIII GGEEL III EGGG THIGGINE			COSTS APPRVD	22.00	J	10.00
44.00	MI SCELLANEOUS I NCOME	В		ADULTS & PEDIATRICS	30.00	0	
45. 00 46. 00	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		NEONATAL INTENSIVE CARE UNIT OPERATING ROOM	35. 00 50. 00	0	45. 00 46. 00
46. 01	MI SCELLANEOUS I NCOME	В	-513, 752	RADI OLOGY-DI AGNOSTI C	54. 00	0	46. 01
46. 02	MI SCELLANEOUS I NCOME	В		LABORATORY	60.00	0	46. 02
46. 03 46. 04	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		SLEEP LAB PHYSICAL THERAPY	65. 01 66. 00	0	46. 03 46. 04
46. 05	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69. 00	0	46. 05
46.06	MI SCELLANEOUS I NCOME	В		HOSPITAL BASED RETAIL	73. 01	0	46. 06
47 07	MI COELL ANEQUE LINCOME	D.	04.707	PHARMACI ES	7/ 07	0	47 07
46. 07 46. 08	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		CARDIAC REHABILITATION SUBSTANCE ABUSE CLINIC	76. 97 90. 01	0	46. 07 46. 08
46. 09	MI SCELLANEOUS I NCOME	В		ONCOLOGY CLINIC	90. 03	0	46. 09
46. 10	MI SCELLANEOUS I NCOME	В		EMERGENCY	91.00	0	46. 10
46. 11 46. 12	MI SCELLANEOUS I NCOME NON-ALLOWABLE MARKETING	B A		THERAPIES TO OTHER ENTITIES OTHER ADMINISTRATIVE AND	194. 22 5. 06	0	46. 11 46. 12
40. 12	NON ALLOWABLE MARKETING			GENERAL ADMINITION OF AND	3.00	0	40. 12
46. 13	NON-ALLOWABLE MARKETING	A		RESPI RATORY THERAPY	65. 00	0	46. 13
46. 14 46. 15	NON-ALLOWABLE MARKETING CORPORATE TELEPHONE	A A	·	PHYSICAL THERAPY OTHER ADMINISTRATIVE AND	66. 00 5. 06	0	46. 14 46. 15
10. 10	SOM SIGNE TELEFININE	, ,		GENERAL THE	0.00	J	10. 10
46. 16	EMPLOYEE BENEFITS OFFSET	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
46. 18	HAF FEES	A		OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	46. 18
46. 19	TELEVISION DEPRECIATION	А		NEW CAP REL COSTS-BLDG &	1. 00	9	46. 19
44 20	NON ALLOWARIE DE DELMO	Δ.		FIXT	F 0/	0	46. 20
46. 20	NON-ALLOWABLE PT REIMB.	A		OTHER ADMINISTRATIVE AND GENERAL	5. 06	U	40. 20
46. 21	LOSS ON EXTINGUISHMENT OF DEBT	A	298, 071	NEW CAP REL COSTS-BLDG &	1. 00	14	46. 21
46. 22	CARRY ADDICTION AND PAIN CLINIC	A		FIXT SUBSTANCE ABUSE CLINIC	90. 01	0	46. 22
40. 22	START UP C	^	03, 077	SUBSTANCE ABOSE CETNIC	70.01	0	40. 22
46. 23	CONTRIBUTION EXPENSE	A		ADULTS & PEDIATRICS	30. 00	0	46. 23
46. 24 46. 25	CONTRIBUTION EXPENSE CONTRIBUTION EXPENSE	A A		CARDI AC CATHETERI ZATI ON PHYSI CAL THERAPY	59. 00 66. 00	0	46. 24 46. 25
46. 26	CONTRIBUTION EXPENSE	A	·	ONCOLOGY CLINIC	90. 03	0	46. 26
46. 27	RECRUITING FEES	A		ADULTS & PEDIATRICS	30.00	0	46. 27
46. 28 46. 29	RECRUITING FEES RECRUITING FEES	A A		INTENSIVE CARE UNIT EMERGENCY	31. 00 91. 00	0	46. 28 46. 29
46. 30	NON-ALLOWABLE COST	A		ADULTS & PEDIATRICS	30.00	0	46. 30
46. 31	OTHER ADJUSTMENTS (SPECIFY)	A	0		0. 00	Ō	46. 31
46. 32	(3) OTHER ADJUSTMENTS (SPECIFY)	А	^		0. 00	0	46. 32
40. 32	(3)	^	U		0.00	U	40. 32
46. 33	OTHER ADJUSTMENTS (SPECIFY)	A	0		0. 00	0	46. 33
46. 34	(3) OTHER ADJUSTMENTS (SPECIFY)	А	0		0.00	0	46. 34
10. 54	(3)				0.00	O	10.54
46. 35	OTHER ADJUSTMENTS (SPECIFY)	A	0		0. 00	0	46. 35
46. 36	(3) OTHER ADJUSTMENTS (SPECIFY)	А	n		0. 00	0	46. 36
	(3)						
46. 37	OTHER ADJUSTMENTS (SPECIFY) (3)	А	0		0. 00	0	46. 37
	(4)	i l					
46. 38	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	46. 38

Health Financial Systems	BALL MEMORIA	L HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Peri od:	Worksheet A-8		
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 9:2	pared: 1 am
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
cost center bescription	1.00	2.00	3.00	4.00	5, 00	
50.00 TOTAL (sum of lines 1 thru 49)		-47, 585, 678	1 1	4.00	5.00	50. 00
(Transfer to Worksheet A,		-47, 303, 070				30.00
1.						
column 6, line 200.)						

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

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

 B. Amount Received if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0089 Peri od: Worksheet A-8-1 From 01/01/2023 OFFICE COSTS

OTTTOL	60313			To 12/31/2023	Date/Time Pre 5/24/2024 9: 2	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		NEW CAP REL COSTS-BLDG & FIX		23, 165, 020	0	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT		23, 381, 905	17, 906	2.00
3.00	5. 02	DATA PROCESSING	HOME OFFICE	18, 810, 357	0	3.00
4.00	5. 04	ADMITTI NG	HOME OFFICE	11, 569, 155	0	4.00
4.01	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME OFFICE	11, 502, 487	0	4. 01
4.02	5. 06	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	32, 377, 559	65, 261, 028	4. 02
4.03			HOME OFFICE	0	3, 856	4. 03
4.04	4. 00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	579, 254	579, 254	4.04
4.05	5. 06	OTHER ADMINISTRATIVE AND GEN	RELATED PARTY	743, 338	743, 338	4.05
4.06	13. 00	NURSING ADMINISTRATION	RELATED PARTY	392, 186	392, 186	4.06
4.07	22. 00	I&R SERVICES-OTHER PRGM COST	RELATED PARTY	2, 807, 227	2, 807, 227	4.07
4. 08	30.00	ADULTS & PEDIATRICS	RELATED PARTY	8, 451, 457	8, 451, 457	4. 08
4.09	31.00	INTENSIVE CARE UNIT	RELATED PARTY	53, 200	53, 200	4.09
4. 10	35. 00	NEONATAL INTENSIVE CARE UNIT	RELATED PARTY	1, 506, 443	1, 506, 443	4. 10
4. 11	41.00	SUBPROVIDER - IRF	RELATED PARTY	115, 402	115, 402	4. 11
4. 12	50.00	OPERATING ROOM	RELATED PARTY	9, 840, 216	9, 840, 216	4. 12
4. 13	54. 00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	1, 487, 317	1, 487, 317	4. 13
4. 14	57. 00	CT SCAN	RELATED PARTY	14, 000	14, 000	4. 14
4. 15	59. 00	CARDIAC CATHETERIZATION	RELATED PARTY	13, 685	13, 685	4. 15
4. 16	60.00	LABORATORY	RELATED PARTY	16, 084, 145	16, 084, 145	4. 16
4. 17	63. 00	BLOOD STORING, PROCESSING, &	RELATED PARTY	13, 529	13, 529	4. 17
4. 18			RELATED PARTY	1, 757	1, 757	4. 18
4. 19	76. 98	HYPERBARIC OXYGEN THERAPY	RELATED PARTY	13, 644	13, 644	4. 19
4. 20	90. 01	SUBSTANCE ABUSE CLINIC	RELATED PARTY	500, 240	500, 240	4. 20
4. 21	90. 02	PAIN CLINIC	RELATED PARTY	308, 048	308, 048	4. 21
4. 22	90. 03	ONCOLOGY CLINIC	RELATED PARTY	191, 596	191, 596	4. 22
4. 23	91. 00	EMERGENCY	RELATED PARTY	1, 876, 207	1, 876, 207	4. 23
4. 24	0.00		RELATED PARTY	0	0	4. 24
4. 25	0.00		RELATED PARTY	0	0	4. 25
4. 26	0.00		RELATED PARTY	0	0	4. 26
4. 27	0.00			0	0	4. 27
5.00	0		0	165, 799, 374	110, 275, 681	5. 00
4 TI	amounta on Linea 1 4 (and out		6 1: 1::1::			

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

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

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

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

i ei ilibui	Sellett under title Aviii.			
6.00	В	O. OO I U HEALTH	00.00	6. 00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9. 00
10.00		0.00	0.00	10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:			

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

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

4. 22

4. 23

4.24

4. 25

4.26

4. 27

5.00

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 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.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

4.22

4.23

4.24

4. 25

4.26

4.27

5.00

0

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0

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0

55, 523, 693

0 0 0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0089

					1	To 12/31/2023	B Date/Time Pro 5/24/2024 9:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	micse. A Erric "	I denti fi er	Remuneration	Component	Component	NOL AMOUNT	ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	30. 00	ADULTS & PEDIATRICS	9, 801, 588	9, 217, 228	584, 360	179, 000	14, 652	1. 00
2.00	35. 00	NEONATAL INTENSIVE CARE UNIT	1, 431, 443	1, 431, 443	0	169, 700	0	2. 00
3.00	50.00	OPERATING ROOM	9, 404, 959	9, 404, 959	0	246, 400	0	3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 209, 500	0	1, 209, 500	271, 900	9, 855	4. 00
5.00	76. 98	HYPERBARIC OXYGEN THERAPY	13, 644	13, 644	0	211, 500	0	5. 00
6.00	90. 01	SUBSTANCE ABUSE CLINIC	500, 240	500, 240	0	211, 500	0	6. 00
7.00	90. 02	PAIN CLINIC	308, 048	308, 048	0	211, 500	0	7. 00
8.00	91.00	EMERGENCY	1, 290, 240		1, 290, 240	211, 500	7, 790	8. 00
9.00	69. 00	ELECTROCARDI OLOGY	1, 000	1, 000	0	271, 900		1
10.00	52.00	DELIVERY ROOM & LABOR ROOM	2, 051	2, 051	0	237, 100	0	10.00
11.00	13.00	NURSING ADMINISTRATION	274, 788	274, 788	0	237, 100	0	11.00
200.00			24, 237, 501	21, 153, 401	3, 084, 100		32, 297	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	1, 260, 917	63, 046	0	0	_	
2.00		NEONATAL INTENSIVE CARE UNIT	0	0	0	0	1	2. 00
3.00		OPERATING ROOM	0	0	0	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	1, 288, 257	64, 413	0	0	0	
5.00		HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
6.00		SUBSTANCE ABUSE CLINIC	0	0	0	0	0	
7.00		PAIN CLINIC	702 100	0	0	0	0	,
8. 00 9. 00		EMERGENCY	792, 108	39, 605	0	0	0	8. 00 9. 00
9. 00 10. 00		ELECTROCARDIOLOGY DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	10.00
11. 00		NURSING ADMINISTRATION	0	0	0	0	0	
200.00	13.00	NURSING ADMINISTRATION	3, 341, 282	167, 064	0	0	_	
200.00	Wkst. A Line #	Cost Center/Physician	9, 341, 262 Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		ruentiffei	Share of col.	Limit	Di Sai i Owance			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0	1, 260, 917	0	9, 217, 228		1. 00
2.00	35. 00	NEONATAL INTENSIVE CARE UNIT	0	0	0	1, 431, 443		2. 00
3.00	50.00	OPERATING ROOM	0	0	0	9, 404, 959		3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	1, 288, 257	0	0	1	4. 00
5.00	76. 98	HYPERBARIC OXYGEN THERAPY	0	0	0	13, 644		5. 00
6.00	90. 01	SUBSTANCE ABUSE CLINIC	0	0	0	500, 240		6. 00
7.00		PAIN CLINIC	0	0	0	308, 048		7. 00
8.00	91.00	EMERGENCY	0	792, 108	498, 132	498, 132		8. 00
9.00	69. 00	ELECTROCARDI OLOGY	0	0	0	1, 000		9. 00
10.00	52. 00	DELIVERY ROOM & LABOR ROOM	0	0	0	2, 051		10. 00
11.00	13. 00	NURSING ADMINISTRATION	0	0	0	274, 788		11. 00
200.00			0	3, 341, 282	498, 132	21, 651, 533		200. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Prepared: | Part | Pa Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

					Т	o 12/31/2023	Date/Time Pre 5/24/2024 9: 2	
				CAPI TAL			0,21,2021 7.2	T GIII
			_	RELATED COSTS				
		Cost Center Description	Net Expenses	NEW BLDG &		COMMUNI CATI ONS	DATA	
			for Cost Allocation	FIXT	BENEFITS DEPARTMENT		PROCESSI NG	
			(from Wkst A		DEPARTMENT			
			col . 7)					
			0	1. 00	4. 00	5. 01	5. 02	
1 00		AL SERVICE COST CENTERS	20, 200, 001	20, 200, 001				1 00
1. 00 4. 00		NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	29, 289, 901 24, 026, 405	29, 289, 901 66, 583				1. 00 4. 00
5. 01		COMMUNI CATI ONS	735, 910					5. 01
5.02		DATA PROCESSING	18, 810, 357	0		0	18, 810, 357	5. 02
5.04		ADMITTING	15, 236, 300	97, 073	575, 154	23, 065	0	5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	11, 502, 487	0	0	0	0	5. 05
5.06		OTHER ADMINISTRATIVE AND GENERAL	39, 341, 481	880, 082		20, 476	0	5. 06
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	10, 251, 979 8, 367, 319				0	6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	1, 314, 072	770,000			0	8. 00
9.00		HOUSEKEEPING	5, 005, 478	198, 123	641, 750	44, 581	0	9. 00
10. 00	4	DI ETARY	2, 703, 292	260, 311	385, 290		0	10. 00
11.00		CAFETERI A	1, 202, 680				0	11. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	5, 266, 808	152, 468		20, 798	0	13. 00 14. 00
15. 00		PHARMACY	11, 913, 614 8, 216, 986	332, 785 109, 083		29, 944	0	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0,210,700	0		27, 711	0	16. 00
18. 00		PATIENT TRANSPORTATION	2, 038, 717	11, 559	338, 598	15, 527	0	18. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	4, 864, 011	0	,		0	21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD	3, 917, 897	624, 890			0	22. 00
23. 00		PARAMED ED PRGM I ENT ROUTINE SERVICE COST CENTERS	250, 631	2, 447	39, 074	1, 212	0	23. 00
30. 00		ADULTS & PEDIATRICS	48, 877, 730	2, 842, 634	5, 358, 082	197, 692	2, 077, 826	30. 00
31.00	03100	INTENSIVE CARE UNIT	10, 965, 409			45, 798	464, 293	
32. 00	4	CORONARY CARE UNIT	0	0	1	0	0	32. 00
35. 00		NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	2, 721, 957	143, 420	408, 050	13, 392	111, 854	
40. 00 41. 00		SUBPROVIDER - IPF	2, 312, 710	159, 841	353, 791	12, 160	0 99, 263	40. 00 41. 00
43. 00	4	NURSERY	618, 280	80, 749			26, 839	43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATI NG ROOM	12, 511, 583				1, 833, 477	50.00
51. 00 52. 00	4	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	2, 612, 243 4, 819, 212	130, 558 190, 299			252, 471 225, 402	51. 00 52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	13, 398, 743				2, 063, 289	54. 00
57. 00		CT SCAN	1, 684, 430				438, 075	
58. 00	4	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1		0	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	2, 855, 093 17, 077, 926				980, 559 935, 981	59. 00 60. 00
60. 00		BLOOD LABORATORY	17,077,920	209, 042		21, 311	935, 961	60. 00
63. 00		BLOOD STORING, PROCESSING, & TRANS.	1, 471, 401	Ö	Ö	o	58, 372	
65.00		RESPI RATORY THERAPY	5, 124, 193				248, 653	
65. 01		SLEEP LAB	670, 295				68, 764	
66. 00 67. 00	4	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	6, 542, 066 1, 170, 177				190, 756 57, 974	
68. 00		SPEECH PATHOLOGY	688, 668				34, 049	
68. 01	1	AUDI OLOGY	0	0			0	68. 01
69. 00		ELECTROCARDI OLOGY	2, 319, 706		305, 241	11, 701	376, 183	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 546, 638		0	0	762, 121	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	11, 115, 864 52, 199, 006		0	0	1, 190, 307 3, 121, 107	
73. 00	4	HOSPITAL BASED RETAIL PHARMACIES	22, 946, 782		553, 591	14, 408	167, 097	
74. 00	1	RENAL DIALYSIS	1, 637, 054			0	33, 061	
76. 00		CARDI OPULMONARY	0	0		0	0	
76. 97		CARDI AC REHABI LI TATI ON	1, 156, 292	0			55, 122	
76. 98	4	HYPERBARI C OXYGEN THERAPY	1, 628, 566	_	121, 216	3, 904	184, 619	
77. 00 78. 00		ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
70.00		TIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		70.00
90. 00	09000	CLINIC	0	0	1	0	0	90. 00
90. 01	1	SUBSTANCE ABUSE CLINIC	546, 940				5, 656	
90. 02		PAIN CLINIC	397, 880				26, 001	90. 02
90. 03 91. 00		ONCOLOGY CLINIC EMERGENCY	3, 557, 858 13, 771, 525				397, 002 2, 257, 828	90. 03 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	.5, , 525	2 .5, 550	., . 10, 144	32, 320	_,,	92. 00
92. 01	09201	OBSERVATION BEDS (DISTINCT PART)	1, 165, 070	69, 786	170, 175	6, 229	66, 356	92. 01
05 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES		11 [10			0	95. 00
		OPIOID TREATMENT PROGRAM	0					102. 00
		•	,	•		, -1		

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 9: 21 am CAPI TAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & **EMPLOYEE** COMMUNICATIONS DATA FLXT for Cost BENEFITS **PROCESSING** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 4.00 5. 01 5. 02 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 466, 367, 622 26, 358, 775 23, 459, 317 869, 676 18, 810, 357 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 738 398 47 868 3 073 0 191.00 191. 00 19100 RESEARCH 815, 664 30, 104 132, 896 5, 262 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 194. 01 07951 BSU PHARMACY 0 0 194. 01 0 0 0 194. 02 07952 PAVILLION PHARMACY 0 0 0 194. 02 Ω 194. 03 07953 VENDI NG 0 0 0 194. 03 194. 04 07954 CARELI NE 0 0 0 194. 04 0 0 0 0 0 0 0 194. 05 07955 WELLNESS CENTER 81, 667 0 0 194. 05 1.029 194.06 07956 PHYSICIAN PRACTICE CLINICS 0 0 194.06 0 383, 334 194. 07 07957 PERINATAL CLINIC 0 0 194. 07 194. 08 07958 RENTAL PROPERTY 0 194. 08 1, 368, 508 1, 190, 780 194. 09 07959 ADVERTI SI NG 0 0 194. 09 194. 10 07960 INTEGRA LTAC 0 189, 494 0 0 194 10 48, 955 194. 11 07961 I U HEALTH HOSPI CE 0 0 194. 11 194. 12 07962 POB MEDICAL PAVILLION CONDOS O 0 194. 12 0 194. 13 07963 PEDIATRIC THERAPIES 0 194. 13 -203, 027 11, 696 68, 563 194.14 07964 NEW CASTLE ONCOLOGY 0 194. 14 Γ 194. 15 07965 MARKETING/PUBLIC RELATIONS 0 0 194. 15 35, 803 194. 16 07966 JAY COUNTY HOSPITAL 0 194. 16 1, 033, 038 79, 977 141, 026 3, 762 0 194. 17 194. 17 07967 CARDI NAL HEALTH CHOICE 0 0 194. 18 07968 CHV CARDI NAL HEALTH VENTURES 0 C 0 0 0 194. 18 194. 19 07969 HEALTH CARE CONNECTIONS 0 0 0 194. 19 0 0 194. 20 07970 MEALS ON WHEELS 0 0 0 0 194. 20 194. 21 07971 ST MARY'S SCHOOL 0 194. 21 0 C 0 0 194. 22 07972 THERAPIES TO OTHER ENTITIES 198, 590 0 194. 22 368.865 0 194. 23 194. 23 07973 CANCER CENTER BOUTIQUE 80, 160 13, 716 3, 024 210 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 0 194 24 398, 145 \cap 0 0 194. 25 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 484 81 0 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 0 194. 26 770,026 55, 555 98, 490 3, 146 194. 27 07977 MI DWEST HEALTH STRATEGIES 0 194. 27 0 0 0 194. 28 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 0 0 C 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 0 194. 30 194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194.31 194. 32 07982 RENAL DIALYSIS 0 0 194. 32 C 194. 33 07983 LAB CORP 0 0 194. 33 194. 34 07984 H. O. MATERIALS MGMT 0 0 0 194. 34 0 194. 35 07985 LEASED SPACE o 0 194. 35 355, 033 O 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201. 00 TOTAL (sum lines 118 through 201) 202.00 471, 340, 767 29, 289, 901 24, 092, 988 885, 129 18, 810, 357 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/24/2024 9:21 am

				'	0 12/31/2023	5/24/2024 9: 2	
	Cost Center Description	ADMITTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	MAINTENANCE &	
			OUNTS		ADMI NI STRATI VE	REPAI RS	
		F 04	RECEI VABLE	FA 05	AND GENERAL		
	CENEDAL CEDVICE COCT CENTEDS	5. 04	5. 05	5A. 05	5. 06	6. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 01	00550 DATA PROCESSING						5. 02
5. 02 5. 04	00570 ADMI TTI NG	15 021 502					5. 02
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	15, 931, 592 0	1				5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL		1	41, 073, 020	41, 073, 020		5. 06
6. 00	00600 MAINTENANCE & REPAIRS			25, 339, 715			
7. 00	00700 OPERATION OF PLANT			9, 447, 847		1, 625, 644	1
8. 00	00800 LAUNDRY & LINEN SERVICE			1, 314, 072		1, 625, 644	1
9. 00	00900 HOUSEKEEPING			5, 889, 932			
10. 00	01000 DI ETARY			3, 371, 479		529, 834	
11. 00	01100 CAFETERI A			1, 502, 249			1
13. 00	01300 NURSI NG ADMI NI STRATI ON			6, 189, 585		310, 331	
14. 00	01400 CENTRAL SERVICES & SUPPLY			12, 246, 399			
15. 00	01500 PHARMACY			9, 472, 382			1
16. 00	01600 MEDICAL RECORDS & LI BRARY			9, 472, 302	703, 700	222, 020	1
18. 00	01080 PATIENT TRANSPORTATION			2, 404, 401	229, 457	23, 526	
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		-	4, 879, 576			1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		-	4, 628, 844			
23. 00	02300 PARAMED ED PRGM			293, 364			1
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		vj Oj	273, 304	21, 990	4, 701	23.00
30. 00	03000 ADULTS & PEDIATRICS	1, 759, 877	1, 270, 433	62, 384, 274	5, 953, 448	5, 785, 873	30.00
31. 00	03100 NTENSI VE CARE UNI T	393, 247		14, 009, 346			
32. 00	03200 CORONARY CARE UNIT	373, 247	1	14, 007, 340	1, 330, 740	700, 307	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	94, 738	-	3, 561, 801	339, 910		
40. 00	04000 SUBPROVI DER - I PF	74, 730	· ·	3, 301, 001	337, 710	271, 717	
41. 00	04100 SUBPROVI DER - I RF	84, 074	1 4	3, 082, 531	294, 172	325, 338	
43. 00	04300 NURSERY	22, 732	1	858, 067	81, 887	164, 357	
43.00	ANCI LLARY SERVI CE COST CENTERS	22, 132	. 10, 410	030, 007	01,007	104, 337	1 43.00
50. 00	05000 OPERATING ROOM	1, 552, 918	1, 121, 032	18, 779, 670	1, 792, 181	1, 121, 335	50.00
51. 00	05100 RECOVERY ROOM	213, 838	1	3, 763, 417			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	190, 911	1	6, 058, 311		387, 333	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 747, 565	1	21, 113, 143			1
57. 00	05700 CT SCAN	371, 041	1	3, 048, 794			1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	371,041	1	3, 040, 774	270, 733	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	830, 514	-	5, 942, 082	567, 065		
60. 00	06000 LABORATORY	792, 757		19, 690, 162			
60. 01	06001 BLOOD LABORATORY	7,72,737	372,201	17, 070, 102	1, 077, 072	0	1
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	49, 440	35, 690	1, 614, 903	154, 113		
65. 00	06500 RESPI RATORY THERAPY	210, 604		6, 431, 839			
65. 01	06501 SLEEP LAB	58, 242		932, 807			1
66. 00	06600 PHYSI CAL THERAPY	161, 567		8, 381, 192			
67. 00	06700 OCCUPATI ONAL THERAPY	49, 103		1, 524, 378		78, 771	1
68. 00	06800 SPEECH PATHOLOGY	28, 839	1	889, 722			1
68. 01	06801 AUDI OLOGY	20,007	1	007,722			
	06900 ELECTROCARDI OLOGY	318, 620	1	3, 823, 975	_		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	645, 501	465, 979	15, 420, 239		0 0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 008, 167	· · ·	14, 042, 121			
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 643, 107		59, 872, 918		Ö	
73. 00	07301 HOSPI TAL BASED RETAIL PHARMACIES	141, 528		23, 980, 758		112, 324	
74. 00	07400 RENAL DIALYSIS	28, 002	1	1, 765, 306		95, 613	
76. 00	03160 CARDI OPULMONARY	20,002	20, 214	1, 755, 500	1.50, 407 N	93, 013	
76. 97	07697 CARDI AC REHABI LI TATI ON	46, 687	33, 703	1, 488, 035	142, 006	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	156, 368	1	2, 214, 234		13, 598	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	130, 300	112,000	2, 214, 254	211, 307	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY			0	0	Ö	
70.00	OUTPATIENT SERVICE COST CENTERS		1 9		0		70.00
90. 00	09000 CLINI C	0		0	0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	4, 791	3, 458	744, 168	71, 017	209, 083	
90. 02	09002 PAIN CLINIC	22, 023	1	885, 756		735, 378	
90. 02	09003 ONCOLOGY CLINIC	336, 253		5, 170, 172	493, 400	235, 427	1
91. 00	09100 EMERGENCY	1, 912, 336	1	21, 674, 486		1, 105, 902	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 712, 330	1, 300, 471	∠1,074,400 ∩	2, 000, 440	1, 100, 702	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	56, 202	40, 572	1, 574, 390	150, 247	142, 043	
/Z. UI	OTHER REIMBURSABLE COST CENTERS	30, 202	. 40, 372	1, 374, 370	130, 247	142, 043	, ,2.01
95. 00	09500 AMBULANCE SERVICES	0	ol ol	11, 510	1, 098	23, 428	95. 00
	10200 OPI OI D TREATMENT PROGRAM		1	11, 510			102. 00
102.00	SPECIAL PURPOSE COST CENTERS		·			U	1.02.00
113 00	11300 I NTEREST EXPENSE		T				113. 00
118. 00	1 1	15, 931, 592	11, 502, 487	462, 787, 372	40, 245, 036	21, 791, 945	
	1-55.5 (55 51 Elikes 1 till ough 117)	.5,751,572	.,, 552, 167	.02, 707, 072	.5, 215, 550		1

			1	0 12/31/2023	5/24/2024 9: 2	
Cost Center Description	ADMITTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	MAINTENANCE &	
		OUNTS		ADMI NI STRATI VE	REPAI RS	
		RECEI VABLE		AND GENERAL		
	5. 04	5. 05	5A. 05	5. 06	6. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1		789, 339			190. 00
191. 00 19100 RESEARCH		0	983, 926	93, 898	61, 273	191. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS		0	0	0	0	194. 00
194.01 07951 BSU PHARMACY		0	0	0	0	194. 01
194. 02 07952 PAVILLION PHARMACY		0	0	0	0	194. 02
194. 03 07953 VENDI NG		0	0	0	0	194. 03
194. 04 07954 CARELI NE		0	0	0		194. 04
194. 05 07955 WELLNESS CENTER			82, 696	7, 892	166, 224	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS			383, 334	36, 582	780, 236	194. 06
194. 07 07957 PERINATAL CLINIC			0	0	0	194. 07
194.08 07958 RENTAL PROPERTY			2, 559, 288	244, 238	2, 423, 704	194. 08
194. 09 07959 ADVERTI SI NG			0	0	0	194. 09
194. 10 07960 INTEGRA LTAC			189, 494	18, 084	385, 694	194. 10
194. 11 07961 I U HEALTH HOSPI CE			48, 955	4, 672	99, 643	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS		ol ol	0	0	0	194. 12
194. 13 07963 PEDI ATRI C THERAPI ES		ol ol	-122, 768	0	139, 552	194. 13
194.14 07964 NEW CASTLE ONCOLOGY		ol ol	0	0	0	194. 14
194. 15 07965 MARKETING/PUBLIC RELATIONS		ol ol	35, 803	3, 417	72, 873	194. 15
194. 16 07966 JAY COUNTY HOSPITAL		ol ol	1, 257, 803		162, 784	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE		ol ol	0	0		194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES		ol ol	0	0	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS		ol ol	0	0	0	194. 19
194.20 07970 MEALS ON WHEELS		ol ol	0	0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL		ol ol	0	0	0	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES		ol ol	567, 455	54, 153	0	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE		ol ol	97, 110			194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY		ol ol	398, 145			194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH			565			194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL			927, 217			
194, 27 07977 MI DWEST HEALTH STRATEGIES			. 0	0		194. 27
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP			0	0		194. 28
194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI			0	0		194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE			0	0		194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS			0	0		194. 31
194. 32 07982 RENAL DI ALYSI S			0	0		194. 32
194. 33 07983 LAB CORP			0	0		194. 33
194. 34 07984 H. O. MATERI ALS MGMT			0	0		194. 34
194. 35 07985 LEASED SPACE			355, 033	33, 882		
200.00 Cross Foot Adjustments	1	<u> </u>	000, 000	33, 002	, , , , , , , , , , , , , , , , , , , ,	200. 00
201.00 Negative Cost Centers		ام ار	0	0	n	201.00
202.00 TOTAL (sum lines 118 through 201)	15, 931, 592	11, 502, 487	471, 340, 767	41, 073, 020	-	
202.00 101/12 (30m 11103 110 till bugit 201)	10, 701, 072	-1 11, 302, 407	1, 1, 540, 101	11,075,020	1 2,,757,755	1-02.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 9: 21 am

					12/31/2023	5/24/2024 9: 2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10. 00	11. 00	
4 00	GENERAL SERVICE COST CENTERS						4 00
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT					ļ	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					ļ	4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING					ļ	5. 02
5.04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					ļ	5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS	11 075 110					6.00
7.00	00700 OPERATION OF PLANT	11, 975, 118	1 420 477			ļ	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 439, 477	7 040 544			8. 00
9.00	00900 HOUSEKEEPI NG	184, 793	441	7, 040, 511	4 (40 400		9.00
10.00		242, 796	0	177, 274	4, 643, 130	2 140 400	10.00
11.00	1 1	128, 515	0	93, 833	0	2, 148, 408	11.00
13.00	l l	142, 209	0	103, 832	0	61, 518	13.00
14. 00 15. 00	l l	310, 395	0	226, 630	0	0 88, 570	14.00
	l i	101, 743	856 0	74, 286	0		15.00
16. 00 18. 00	I I	1	0	٥	0	0 45 035	16.00
21. 00		10, 781	0	7, 872	0	45, 925	18. 00 21. 00
	1 1	E02 044	222	422 047	ol Ol	3, 078	
22. 00 23. 00	1 1	582, 846	332 21	423, 867	0	12, 211	22. 00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 282	21	1, 666	υĮ	3, 584	23. 00
30. 00		2, 651, 381	714, 224	1, 940, 407	3, 656, 731	584, 743	30.00
31. 00	l i	415, 352	113, 665	303, 262	187, 071	135, 463	31.00
32. 00	1 1	415, 352	113,000	303, 202	107, 071	133, 403	32.00
35. 00		133, 771	12, 151	97, 671	17 760	39, 610	35. 00
40. 00	1 1	133,771	12, 131	97, 071	17, 760	39, 610	40.00
41. 00	l i	149, 086	40, 682	100 053	EE4 104	35. 968	41. 00
43.00	l l	75, 316	•	108, 853	556, 486	9, 509	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	75, 510	14, 372	54, 991	υĮ	9, 509	43. 00
50. 00		513, 851	130, 573	375, 180	ol	136, 258	50.00
51. 00	1	121, 774	60, 572	88, 911	0	40, 130	51.00
52. 00		177, 495	77, 649		0	45, 130 45, 246	52.00
54. 00		934, 218	64, 670	669, 135	0	151, 085	54.00
57. 00		26, 187	04, 670	19, 120	0	21, 286	57.00
58. 00		20, 187	0	17, 120	0	21, 280	58.00
59. 00		1	20 104	-	0	-	59.00
		209, 267	20, 196	152, 793	0	40, 781	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	270, 154 0	59 0	195, 363	0	63, 035 0	60. 00 60. 01
63. 00	l l	0	0	0	0	0	63.00
65. 00		71, 247	75	52, 020	0	59, 307	65.00
65. 00	06501 SLEEP LAB	71, 247	75	52, 020	0	10, 882	65. 01
66. 00	I I	271, 355	3, 529	64, 924	0	107, 110	66.00
67. 00		36, 097	3, 32 9	26, 355	0	16, 445	67.00
68. 00	1 1	8, 634	0		0		
68. 01	1 1	0,034	0	6, 304	0	9, 682 0	68. 00 68. 01
69. 00	l i	244, 853	13, 915		ol Ol	34, 610	
71. 00		244, 653	13, 913	170,770	0	34, 610	71.00
71.00		0	0	0	0	0	72.00
73. 00	1 1	0	0	0	0	0	73.00
73. 00		51, 472	0	٥	0	42, 616	
74. 00	1 1	43, 814	3, 947	27, 846 31, 990	o o	42, 616 0	73. 01 74. 00
76.00		43, 014	3, 7 47	31, 990	o o	0	76.00
76. 00 76. 97	l l	0	249	0	0	-	
76. 97 76. 98	1 1	4 221	249	0	0	23, 107	76. 97 76. 98
77.00		6, 231	0	0	0	11, 546 0	77.00
78. 00		0	0	0	0	0	78.00
78.00		l V	0	U U	······································	0	78.00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	^		ام	0	90. 00
90.00		95, 812	0	69, 956	0	9, 798	90.00
	1 1		0		0		
90. 02		336, 987	24 770	246, 046	0	7, 876	90. 02
90. 03		107, 884	34, 778		0	48, 353	90. 03
91.00		506, 779	113, 956	370, 017	U	184, 943	91.00
92. 00	,	/E 001	0 (47	47 505		10 405	92.00
92. 01	,	65, 091	9, 647	47, 525	0	18, 425	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS	40 70 1	-	7 00-	_1	-	05 00
	09500 AMBULANCE SERVI CES	10, 736	0	7, 839	0	0	95.00
102.00	0 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
110 0	SPECIAL PURPOSE COST CENTERS				ı		110 00
	0 11300 INTEREST EXPENSE	0.041.05	4 400 ===	, 450 00-	4 440 01-	0 400 757	113. 00
118. 00	. 3 /	9, 241, 204	1, 430, 559	6, 452, 909	4, 418, 048	2, 102, 700	118.00
100 5	NONREI MBURSABLE COST CENTERS		-		_1	2.25-	100 00
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	9, 090	190. 00

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

			To	12/31/2023	Date/Time Pre 5/24/2024 9:2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	ı aiii
oost denter bescription	PLANT	LINEN SERVICE	HOUSEREEFTING	DIEIMA	ON ETERIN	
	7. 00	8. 00	9. 00	10. 00	11. 00	
191. 00 19100 RESEARCH	28, 078	0	20, 501	0	15, 564	191. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	194. 00
194.01 07951 BSU PHARMACY	0	0	0	o	0	194. 01
194. 02 07952 PAVILLION PHARMACY	0	0	0	o		194. 02
194. 03 07953 VENDI NG	0	0	0	o	0	194. 03
194. 04 07954 CARELI NE	0	0	0	o	0	194. 04
194. 05 07955 WELLNESS CENTER	76, 172	8, 918	55, 616	О	0	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	357, 543	0		0	0	194. 06
194. 07 07957 PERINATAL CLINIC	0	0	0	0	0	194. 07
194. 08 07958 RENTAL PROPERTY	1, 110, 662	0	275, 547	0	0	194. 08
194. 09 07959 ADVERTI SI NG	0	0	0	0	0	194. 09
194. 10 07960 INTEGRA LTAC	176, 744	0	0	225, 082	0	194. 10
194. 11 07961 I U HEALTH HOSPICE	45, 661	0	33, 339	0	0	194, 11
194. 12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0	194, 12
194. 13 07963 PEDI ATRI C THERAPI ES	63, 950	0	0	0	0	194. 13
194. 14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0	194, 14
194. 15 07965 MARKETI NG/PUBLIC RELATIONS	33, 394	0	0	0	0	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	74, 596		54, 465	0	11, 127	
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	o		194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	o	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	o	0	194. 19
194.20 07970 MEALS ON WHEELS	0	0	0	o	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	o	0	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	0	0	0	o	0	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	12, 793	0	9, 341	o	621	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	371, 357	0	0	o	0	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0	0	o	0	194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	51, 818	0	37, 834	o	9, 306	194. 26
194. 27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	o		194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	o	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0	194. 29
194. 30 07980 CARDINAL HEALTH ALLIANCE	0	0	0	0	0	194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 31
194. 32 07982 RENAL DI ALYSI S	0	0	0	0	0	194. 32
194. 33 07983 LAB CORP	0	0	0	0	0	194. 33
194.34 07984 H.O. MATERIALS MGMT	0	0	0	0	0	194. 34
194. 35 07985 LEASED SPACE	331, 146	0	o	o	0	194. 35
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	o	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	11, 975, 118	1, 439, 477	7, 040, 511	4, 643, 130	2, 148, 408	1

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/24/2024 9:21 am

) 12/31/2023	5/24/2024 9: 2	
						OTHER GENERAL	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SERVI CE PATI ENT	
	cost center bescription	ADMI NI STRATI ON	SERVICES &	FIIANWACI	RECORDS &	TRANSPORTATION	
			SUPPLY		LI BRARY		
		13.00	14. 00	15. 00	16. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS						4. 00 5. 01
5. 01	00550 DATA PROCESSING						5. 01
5. 04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	7, 398, 159					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	14, 629, 471				14. 00
15. 00	01500 PHARMACY	0	40, 638	10, 904, 469			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	O	0	0	0		16.00
18.00	01080 PATIENT TRANSPORTATION	77, 600	0	0	0	2, 799, 562	18.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	7, 573	0	0	1	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 286, 553	F71 710	49, 222	0	309, 238	20.00
30.00	03100 INTENSIVE CARE UNIT	875, 980	571, 718 188, 342	49, 222 32, 805	0		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	075, 760	100, 342 N	32, 803	0	09, 100	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	257, 492	38, 436	2, 524	0	16, 647	35. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	230, 266	12, 110	418	0	14, 773	41.00
43.00	04300 NURSERY	57, 208	0	0	0	3, 994	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	284, 718	2, 445, 779	16, 551	0		50.00
51.00	05100 RECOVERY ROOM	284, 939	27, 902	12, 744	0		51.00
52. 00 54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC	257, 602 198, 741	71, 652 394, 348	6, 852 34, 965	0	33, 546 307, 074	52. 00 54. 00
57. 00	05700 CT SCAN	190, 741	26, 702	4, 139	0	65, 198	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	Ö	20, 702	4, 137	0	03, 170	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	147, 485	638, 190	9, 654	0	145, 934	59. 00
60.00	06000 LABORATORY	0	0	0	0	139, 300	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	8, 687	63.00
65. 00	06500 RESPI RATORY THERAPY	220	197, 156	0	0	37, 006	65. 00
65. 01	06501 SLEEP LAB	0	17, 446	11	0	10, 234	65. 01
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	9, 176 82	0	0	28, 390	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		20	0	0	5, 067	
68. 01	06801 AUDI OLOGY	Ö	0	0	0	0,007	68. 01
69.00	06900 ELECTROCARDI OLOGY	42, 217	5, 831	561	0	55, 986	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 246, 973	0	0	113, 425	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	4, 305, 474	0	0	177, 150	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	7, 752, 895	0	464, 569	73. 00
73. 01	07301 HOSPI TAL BASED RETAIL PHARMACI ES	0	382	1, 555, 706	0	24, 869	73. 01
74. 00	07400 RENAL DI ALYSI S 03160 CARDI OPULMONARY	0	2, 839	148	0	4, 920	74.00
76. 00 76. 97	07697 CARDI AC REHABI LI TATI ON	6, 944	576	0	0	0 8, 204	76. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	65, 586	84, 116	0	0	27, 476	76. 98
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	05,500	04, 110	0	0	27, 470	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	Ö	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	11, 133	567	0	0	842	90. 01
90. 02	09002 PAIN CLINIC	19, 731	7, 536	108	0	3, 870	90. 02
90. 03	09003 ONCOLOGY CLINIC	197, 969	40, 968	12, 707	0	59, 085	90. 03
91.00	09100 EMERGENCY	993, 704	238, 030	67, 042	0	336, 027	91.00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	101, 410	4, 892	1, 213	0	9, 876	92. 00 92. 01
7Z. U I	OTHER REIMBURSABLE COST CENTERS	101,410	4, 092	1,213	0	7, 0/0	72. UI
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	1	102. 00
	SPECIAL PURPOSE COST CENTERS						
113. 00	11300 INTEREST EXPENSE			<u> </u>			113. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

				To	12/31/2023	Date/Time Prep	
						5/24/2024 9: 21 OTHER GENERAL	l am
						SERVI CE	
Co	ost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PATIENT	
C	ost center bescription	ADMI NI STRATI ON	SERVICES &	THANWACT		TRANSPORTATION	
		, IDIMITIVE STEATER ON	SUPPLY		LI BRARY		
		13.00	14.00	15. 00	16. 00	18. 00	
118. 00 SI	UBTOTALS (SUM OF LINES 1 through 117)	7, 397, 498	14, 625, 454	9, 560, 265	0	2, 799, 562	118. 00
NONREIM	BURSABLE COST CENTERS						
190. 00 19000 G	IFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	0	0	0	190. 00
191. 00 19100 RI	ESEARCH	0	21	0	0	0	191. 00
194. 00 07950 0	THER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 BS	SU PHARMACY	0	0	0	0	0	194. 01
194. 02 07952 PA	AVILLION PHARMACY	441	1, 116	1, 344, 204	0	0	194. 02
194. 03 07953 VI	ENDI NG	0	0	0	0	0	194. 03
194. 04 07954 C	ARELI NE	0	0	0	0	0	194. 04
194. 05 07955 WI	ELLNESS CENTER	0	0	0	0	0	194. 05
194. 06 07956 PI	HYSICIAN PRACTICE CLINICS	0	0	0	0	0	194. 06
194. 07 07957 PI	ERINATAL CLINIC	0	0	0	0	0	194. 07
194. 08 07958 RI	ENTAL PROPERTY	0	184	0	0	0	194. 08
194. 09 07959 AI	DVERTI SI NG	0	0	0	0	0	194. 09
194. 10 07960 11	NTEGRA LTAC	0	0	0	0	0	194. 10
194. 11 07961 11	U HEALTH HOSPICE	0	0	0	0	0	194. 11
194. 12 07962 PC	OB MEDICAL PAVILLION CONDOS	0	0	0	0	0	194. 12
194. 13 07963 PI	EDIATRIC THERAPIES	0	2, 694	0	0	0	194. 13
	EW CASTLE ONCOLOGY	0	0	0	0	0	194. 14
194. 15 07965 M	ARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 15
1 1	AY COUNTY HOSPITAL	0	0	0	0	0	194. 16
	ARDINAL HEALTH CHOICE	0	0	0	0		194. 17
1 1	HV CARDINAL HEALTH VENTURES	0	0	0	0	0	194. 18
1 1	EALTH CARE CONNECTIONS	0	0	0	0		194. 19
	EALS ON WHEELS	0	0	0	0		194. 20
1 1	T MARY'S SCHOOL	0	0	0	0		194. 21
	HERAPIES TO OTHER ENTITIES	220	0	0	0		194. 22
1 1	ANCER CENTER BOUTIQUE	0	0	0	0		194. 23
1 1	OSC BALL OUTPATIENT SURGERY	0	0	0	0		194. 24
	ARDI NAL BEHAVI ORAL HEALTH	0	0	0	0		194. 25
1 1	LACKFORD COMMUNITY HOSPITAL	0	0	0	0	- 1	194. 26
	IDWEST HEALTH STRATEGIES	0	0	0	0		194. 27
	ARDINAL SELECT RISK RETENTION GRP	0	0	0	0		194. 28
1 1	OME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	- 1	194. 29
	ARDINAL HEALTH ALLIANCE	0	0	0	0		194. 30
1 1	THER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 31
194. 32 07982 RI		0	0	0	0	- 1	194. 32
194. 33 07983 L		0	0	0	0		194. 33
1 1	O. MATERIALS MGMT	0	0	0	0		194. 34
194. 35 07985 LI		0	0	0	0		194. 35
1 1	ross Foot Adjustments	_	=	_	_		200. 00
1 1	egative Cost Centers	0	0	0	0		201. 00
202. 00 TO	OTAL (sum lines 118 through 201)	7, 398, 159	14, 629, 471	10, 904, 469	0	2, 799, 562	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Part | Prepared: | Prepar Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

				10	0 12/31/2023	Date/lime Prep 5/24/2024 9:2	
		INTERNS &	RESI DENTS			0,21,2021 ,12	Cana
	Cost Center Description	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown	
						Adjustments	
	CENEDAL CEDALCE COCT CENTEDO	21.00	22. 00	23. 00	24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00 5. 01 5. 02 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	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						4. 00 5. 01 5. 02 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
18. 00	01080 PATIENT TRANSPORTATION						18. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	5, 348, 322					21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		7, 369, 310				22. 00
23. 00	O2300 PARAMED ED PRGM			333, 894			23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 250, 151	4, 478, 295	0	95, 616, 258	-7, 728, 446	30. 00
31. 00	03100 NTENSI VE CARE UNI T	636, 452	876, 951	Ö	20, 087, 116	-1, 513, 403	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	38, 187	52, 617	0	4, 900, 494	-90, 804	35. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	4, 850, 683	0	40. 00 41. 00
43.00	04300 NURSERY	0	0	0	1, 319, 701	0	43.00
	ANCILLARY SERVICE COST CENTERS			_			
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	163, 356		0	26, 257, 408 5, 062, 850	-388, 440 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	o	0	7, 823, 438	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	184, 571	254, 316	0	28, 359, 800	-438, 887	54. 00
57. 00	05700 CT SCAN	0	0	0	3, 559, 524	0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	0	8, 330, 114	0	58. 00 59. 00
60. 00	06000 LABORATORY	0	o o	o O	22, 826, 680	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	o	0	o	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	204 023	0	1, 777, 703	F20 (01	63.00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	222, 758	306, 933 0	0	8, 147, 841 1, 060, 400	-529, 691 0	65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	0	o	Ō	10, 257, 666	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	1, 836, 230	0	67. 00
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 AUDI OLOGY	0	0	0	1, 023, 178	0	68. 00 68. 01
69. 00	06900 ELECTROCARDI OLOGY	237, 609	327, 395	0	5, 864, 981	-565, 004	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	22, 252, 221	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	19, 864, 813	0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0	333, 894	74, 138, 068 28, 084, 505	0	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	0	o	0	2, 117, 044	0	74. 00
76. 00	03160 CARDI OPULMONARY	0	o	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	. 0	0	1, 669, 121	0	76. 97
76. 98 77. 00	07698 HYPERBARIC OXYGEN THERAPY 07700 ALLOGENEIC HSCT ACQUISITION	4, 243	5, 846	0	2, 644, 185	-10, 089 0	76. 98 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS				٩	Ü	70.00
90. 00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 90. 02	09001 SUBSTANCE ABUSE CLINIC 09002 PAIN CLINIC	105, 015	0 144, 697	0	1, 212, 376 2, 577, 529	0 -249, 712	90. 01 90. 02
90. 02	09003 ONCOLOGY CLINIC	79, 557		0	6, 668, 689	-189, 176	90. 02
91. 00	09100 EMERGENCY	365, 960		o	28, 529, 533	-870, 207	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				6 40 : =-	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	2, 124, 759	0	92. 01
95. 00	09500 AMBULANCE SERVICES	0	O	0	54, 611	0	95. 00
	10200 OPIOID TREATMENT PROGRAM	0	1			0	102. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 9: 21 am INTERNS & RESIDENTS SERVI CES-SALAR SERVI CES-OTHER Cost Center Description PARAMED ED Subtotal Intern & Residents Cost Y & FRINGES PRGM COSTS PRGM & Post Stepdown Adjustments 21. 00 22.00 23. 00 24. 00 25. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 5, 287, 859 7, 286, 000 333, 894 450, 899, 519 <u>-12, 573, 859</u> 118. 00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 873 759 0 191. 00 19100 RESEARCH 60, 463 83, 310 1, 347, 034 -143, 773 191. 00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194. 00 194. 01 07951 BSU PHARMACY 0 0 0 0 194. 01 194. 02 07952 PAVILLION PHARMACY 0 0 0 194. 02 1, 345, 761 0 194. 03 07953 VENDI NG 0 0 0 0 194. 03 194. 04 07954 CARELI NE 0 0 0 194. 04 194. 05 07955 WELLNESS CENTER 0 397, 518 0 194. 05 0 0 0 194. 06 194.06 07956 PHYSICIAN PRACTICE CLINICS 0 1, 658, 654 194. 07 07957 PERINATAL CLINIC 0 0 0 194. 07 194. 08 07958 RENTAL PROPERTY 0 194. 08 6, 613, 623 194. 09 07959 ADVERTI SI NG 0 0 194. 09 0 194. 10 07960 INTEGRA LTAC Ω 0 995 098 0 194 10 194. 11 07961 I U HEALTH HOSPI CE 0 194. 11 232, 270 194. 12 07962 POB MEDICAL PAVILLION CONDOS 0 0 194. 12 194. 13 07963 PEDIATRIC THERAPIES 0 194. 13 0 83, 428 194.14 07964 NEW CASTLE ONCOLOGY 0 0 194. 14 194. 15 07965 MARKETING/PUBLIC RELATIONS 0 145, 487 0 194. 15 194. 16 07966 JAY COUNTY HOSPITAL 0 194. 16 1, 680, 810 194. 17 07967 CARDI NAL HEALTH CHOICE 0 194. 17 0 0 194. 18 07968 CHV CARDI NAL HEALTH VENTURES 0 0 0 194. 18 194. 19 07969 HEALTH CARE CONNECTIONS 0 0 194. 19 0 o 194. 20 07970 MEALS ON WHEELS 0 0 194. 20 194. 21 07971 ST MARY'S SCHOOL 0 0 0 194. 21 0 194. 22 07972 THERAPIES TO OTHER ENTITIES 621, 828 0 194. 22 0 194. 23 194. 23 07973 CANCER CENTER BOUTIQUE 0 0 157, 049 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 0 0 1, 617, 879 0 194 24 0 194. 25 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 619 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 0 194. 26 1, 227, 738 194. 27 07977 MI DWEST HEALTH STRATEGIES 0 194. 27 0 194. 28 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 0 0 194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI 0 0 0 194. 29 194. 30 07980 CARDI NAL HEALTH ALLI ANCE 0 0 194. 30 0 0 194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS 0 0 194.31 194. 32 07982 RENAL DIALYSIS 0 0 194. 32 0 0 194. 33 07983 LAB CORP 0 0 0 194. 33 194. 34 07984 H. O. MATERIALS MGMT 0 0 0 194. 34 0 194. 35 07985 LEASED SPACE 0 0 194. 35 1, 442, 693 Ω 200.00 Cross Foot Adjustments 0 0 0 0 200. 00 201.00 Negative Cost Centers 0 0 201. 00 0 TOTAL (sum lines 118 through 201) 471, 340, 767 202.00 5, 348, 322 7, 369, 310 333, 894 -12, 717, 632 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

BOLIGABLE SERVICE COST CONTRES 1.00 COCOCO APPEA CAP SET COSTS-RID A. FLAT CO.				5/24/2024 9:	<u>21 am</u>
BERRIAL SERVICE COST CERTICS 1.00		Cost Center Description			
1.00 OUTCOME PROPERTY COSTS, BITS & FINT			26. 00		
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91. 00					
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92. 01			27,007,020		
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NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 873, 759 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190. 00			438 325 660		
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Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS BALL MEMORIAL HOSPITAL Provider CCN: 15-0089

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared:

		To 12/31/2023 Date/lime Prepared: 5/24/2024 9:21 am
Cost Center Description	Total	3/24/2024 7.21 dill
	26. 00	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	194. 00
194.01 07951 BSU PHARMACY	o	194. 01
194. 02 07952 PAVILLION PHARMACY	1, 345, 761	194. 02
194. 03 07953 VENDI NG	0	194. 03
194. 04 07954 CARELI NE	О	194. 04
194. 05 07955 WELLNESS CENTER	397, 518	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	1, 658, 654	194. 06
194. 07 07957 PERI NATAL CLI NI C	0	194. 07
194. 08 07958 RENTAL PROPERTY	6, 613, 623	194. 08
194. 09 07959 ADVERTI SI NG	0	194. 09
194.10 07960 INTEGRA LTAC	995, 098	194. 10
194. 11 07961 I U HEALTH HOSPI CE	232, 270	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	194. 12
194. 13 07963 PEDI ATRI C THERAPI ES	83, 428	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATIONS	145, 487	194. 15
194.16 07966 JAY COUNTY HOSPITAL	1, 680, 810	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	194. 17
194. 18 07968 CHV CARDI NAL HEALTH VENTURES	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	194. 19
194. 20 07970 MEALS ON WHEELS	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	621, 828	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	157, 049	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	1, 617, 879	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	619	194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	1, 227, 738	194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	194. 27
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP	0	194. 28
194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	194. 31
194. 32 07982 RENAL DI ALYSI S	0	194. 32
194. 33 07983 LAB CORP	0	194. 33
194. 34 07984 H. O. MATERI ALS MGMT	1 442 (02	194. 34
194. 35 07985 LEASED SPACE	1, 442, 693	194. 35
200.00 Cross Foot Adjustments	0	200.00
201.00 Negative Cost Centers	4E0 422 12E	201. 00
202.00 TOTAL (sum lines 118 through 201)	458, 623, 135	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

					10	12/31/2023	Date/lime Prep 5/24/2024 9:2	
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
			0	1. 00	2A	4. 00	5. 01	
4 00		AL SERVICE COST CENTERS	T					4 00
1. 00 4. 00		NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	0	66, 583	66, 583	66, 583		1. 00 4. 00
5. 01 5. 02		COMMUNI CATI ONS DATA PROCESSI NG	0	29, 331 0		332 0	29, 663 0	5. 01 5. 02
5.04	00570	ADMITTING	ő	97, 073	_	1, 591	773	5. 04
5. 05 5. 06		CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE AND GENERAL	0 0	0 880, 082	0 880, 082	0 2, 299	0 686	5. 05 5. 06
6.00	00600	MAINTENANCE & REPAIRS	0	14, 579, 195	14, 579, 195	1, 340	808	6. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	798, 688 0		747 0	401 0	7. 00 8. 00
9.00	00900	HOUSEKEEPI NG	0	198, 123		1, 775	1, 494	9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	0	260, 311 137, 786		1, 066 414	757 402	10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	0	152, 468		2, 073	697	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	332, 785		0	0	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	109, 083 0		3, 088 0	1, 004 0	15. 00 16. 00
18. 00		PATIENT TRANSPORTATION	0	11, 559	_	937	520	18. 00
21. 00		I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	40	35	21. 00
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	0	624, 890 2, 447		227 108	138 41	22. 00 23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	_, _,,		14, 760	6, 624	30.00
31. 00 32. 00	1	CORONARY CARE UNIT		445, 313 0		3, 904 0	1, 535 0	31. 00 32. 00
35. 00	02060	NEONATAL INTENSIVE CARE UNIT	0	143, 420	143, 420	1, 129	449	35.00
40. 00 41. 00		SUBPROVIDER - IPF SUBPROVIDER - IRF	0	0 159, 841	0 159, 841	0 979	0 408	40. 00 41. 00
43. 00		NURSERY	0	80, 749		249	108	43. 00
		LARY SERVICE COST CENTERS						
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	0	550, 918 130, 558		3, 219 1, 069	1, 544 455	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	190, 299		1, 326	513	52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	0	1, 001, 608		4, 396	1, 712	54. 00
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	28, 076 0		697 0	241 0	57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	224, 363	_	1, 212	462	59. 00
60.00	1	LABORATORY	0	289, 642		1	714	60.00
60. 01 63. 00	1	BLOOD LABORATORY BLOOD STORING, PROCESSING, & TRANS.	0	0	-	0	0	60. 01 63. 00
65.00	06500	RESPI RATORY THERAPY	Ö	76, 387	_	1, 660	672	65. 00
65. 01		SLEEP LAB	0	0		248		65. 01
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	290, 930 38, 700		2, 885 463	1, 214	66. 00 67. 00
68. 00	06800	SPEECH PATHOLOGY	0	9, 257		290	110	68. 00
68. 01		AUDI OLOGY	0	0	0	0	0	68. 01
69. 00 71. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	262, 516 0	262, 516 0	844 0	392 0	69. 00 71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS HOSPITAL BASED RETAIL PHARMACIES	0	0	0 EE 10E	1 521	0	73.00
73. 01 74. 00		RENAL DIALYSIS		55, 185 46, 975		1, 531 0	483 0	73. 01 74. 00
76.00	03160	CARDI OPULMONARY	0	0	0	0	0	76.00
76. 97		CARDIAC REHABILITATION	0	0	0 4 401	521	262	76. 97
76. 98 77. 00	1	HYPERBARI C OXYGEN THERAPY ALLOGENEI C HSCT ACQUISITION		6, 681 0	6, 681 0	335 0	131	76. 98 77. 00
78. 00	1	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.00		TIENT SERVICE COST CENTERS				_		00.00
90. 00 90. 01		CLINIC SUBSTANCE ABUSE CLINIC	0	0 102, 724		0 214	0 111	90. 00 90. 01
90. 02	09002	PAIN CLINIC	0	361, 296	361, 296	166	89	90. 02
90. 03		ONCOLOGY CLINIC	0	115, 667		1, 395	548	
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0	543, 336	543, 336 0	4, 831	2, 095	91. 00 92. 00
92. 01	09201	OBSERVATION BEDS (DISTINCT PART)	0	69, 786	-	471	209	92. 01
05 00		REIMBURSABLE COST CENTERS		11 510	11 510		0	95. 00
		AMBULANCE SERVICES OPIOID TREATMENT PROGRAM	0 0			0	0	95. 00 102. 00
					!		·	

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am CAPI TAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly NEW BLDG & Subtotal COMMUNI CATI ONS Assigned New FLXT **BENEFLTS** DEPARTMENT Capi tal Related Costs 1.00 2A 4.00 5.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 26, 358, 775 118.00 26, 358, 775 64,832 29, 146 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 132 103 190. 00 191. 00 19100 RESEARCH 176 191. 00 0 0 30, 104 30, 104 368 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 0 0 194. 01 07951 BSU PHARMACY 0 0 0 194. 01 194. 02 07952 PAVILLION PHARMACY 0 0 0 194, 02 Ω 194. 03 07953 VENDI NG 0 0 194, 03 C 194. 04 07954 CARELI NE 0 194. 04 194. 05 07955 WELLNESS CENTER 0 194. 05 81,667 81, 667 0 0 0 0 0 0 0 194.06 07956 PHYSICIAN PRACTICE CLINICS 0 194. 06 383.334 383.334 194. 07 07957 PERINATAL CLINIC 0 194. 07 194. 08 07958 RENTAL PROPERTY 1, 190, 780 1, 190, 780 0 194. 08 194. 09 07959 ADVERTI SI NG 0 194. 09 0 194. 10 194. 10 07960 I NTEGRA LTAC 189, 494 189, 494 194. 11 07961 I U HEALTH HOSPICE 48, 955 48, 955 0 194, 11 194. 12 07962 POB MEDICAL PAVILLION CONDOS 0 194. 12 194. 13 07963 PEDIATRIC THERAPIES 32 0 194. 13 68, 563 68. 563 194. 14 07964 NEW CASTLE ONCOLOGY 0 0 194 14 194. 15 07965 MARKETING/PUBLIC RELATIONS 35, 803 35, 803 0 0 194. 15 194. 16 07966 JAY COUNTY HOSPITAL 79, 977 79, 977 126 194. 16 390 194. 17 07967 CARDI NAL HEALTH CHOICE 0 0 194. 17 0 194. 18 07968 CHV CARDI NAL HEALTH VENTURES 0 0 194. 18 C 194. 19 07969 HEALTH CARE CONNECTIONS 0 0 0 194. 19 0 194. 20 07970 MEALS ON WHEELS 0 0 194. 20 194. 21 07971 ST MARY'S SCHOOL 0 0 194. 21 0 0 194. 22 07972 THERAPIES TO OTHER ENTITIES 0 194. 22 0 549 13, 716 194. 23 07973 CANCER CENTER BOUTIQUE 13, 716 7 194. 23 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 0 194. 24 398, 145 398, 145 0 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 0 0 194 25 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 55, 555 55, 555 272 105 194. 26 194. 27 07977 MI DWEST HEALTH STRATEGIES 0 194. 27 0 0 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 0 194. 28 0 C 0 194. 29 194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI 0 C 194. 30 07980 CARDI NAL HEALTH ALLI ANCE 0 0 0 0 194. 30 194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 31 0 0 194. 32 194. 32 07982 RENAL DIALYSIS C 0 0 194. 33 07983 LAB CORP C 0 0 194. 33 194. 34 07984 H. O. MATERIALS MGMT 0 0 0 194. 34 0 194. 35 07985 LEASED SPACE 355.033 355.033 0 0 194. 35 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 29, 289, 901 202.00 TOTAL (sum lines 118 through 201) 29, 289, 901 66, 583 29, 663 202. 00

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

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Prepared: |

				1	0 12/31/2023	Date/lime Prep 5/24/2024 9:2	
	Cost Center Description	DATA	ADMI TTI NG	CASHI ERI NG/ACC		MAINTENANCE &	
		PROCESSI NG		OUNTS RECEI VABLE	ADMINISTRATIVE AND GENERAL	REPAI RS	
		5. 02	5. 04	5. 05	5. 06	6. 00	
	GENERAL SERVI CE COST CENTERS			T			
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	O					5. 02
5.04	00570 ADMITTING	0	99, 437				5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0			5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	0	0	0	883, 067	14 (22 240	5. 06
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0	0	51, 997 19, 387	14, 633, 340 857, 002	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE		0	0	2, 696	037,002	8.00
9.00	00900 HOUSEKEEPI NG	O	0	0	12, 086	212, 588	9. 00
10.00	01000 DI ETARY	0	0	0	6, 918	279, 316	10. 00
11.00	01100 CAFETERI A	0	0	0	-,	147, 846	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	0		163, 600 357, 083	13. 00 14. 00
15. 00	01500 PHARMACY	0	0	Ö	19, 437	117, 047	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	O	0	0	o	0	16. 00
18. 00	01080 PATIENT TRANSPORTATION	0	0	0	4, 934	12, 403	18. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	10, 013	(70.515	21.00
22. 00 23. 00	02200 1 &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	0	0	0		670, 515 2, 626	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	J	0		002	2,020	23.00
30.00	03000 ADULTS & PEDI ATRI CS	0	10, 889	0	127, 918	3, 050, 174	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	2, 433		28, 747	477, 826	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	7 200	152,000	32.00
35. 00 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		586 0	0	7, 309	153, 892 0	35. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	520	-	6, 325	171, 511	41. 00
43. 00	04300 NURSERY	0	141	Ō	-, -	86, 645	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	9, 608			591, 142	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	1, 323 1, 181	0	.,	140, 090 204, 193	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 812			1, 074, 737	54. 00
57. 00	05700 CT SCAN	O	2, 296		6, 256	30, 125	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	o	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	5, 139		12, 193	240, 744	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	4, 905 0		40, 404	310, 789 0	60. 00 60. 01
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	306	1	3, 314	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	1, 303	•		81, 964	65. 00
65. 01	06501 SLEEP LAB	0	360	•	1, 914	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	1, 000		17, 198	312, 171	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	304 178		3, 128 1, 826	41, 526 9, 932	67. 00 68. 00
	06801 AUDI OLOGY	0	0		1, 020	9, 932	
	06900 ELECTROCARDI OLOGY	0	1, 971	Ö	7, 847	281, 683	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 994		31, 642	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6, 238		28, 814	0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	0	17, 219 876		122, 859 49, 209	0 59, 214	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	0	173		3, 622	50, 405	74. 00
76. 00	03160 CARDI OPULMONARY	0	0		0	0	76. 00
76. 97	07697 CARDI AC REHABILI TATI ON	0	289	0	3, 053	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	967	0	4, 544	7, 169	76. 98
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	_	0	77.00
76.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	0	l u	U	78. 00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	o	30	0	1, 527	110, 224	90. 01
90. 02	09002 PAIN CLINIC	0	136		1, 818	387, 674	90. 02
90. 03	09003 ONCOLOGY CLINIC	0	2, 080		10, 609	124, 112 583, 006	90. 03
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	U	11, 832	0	44, 476	583, 006	91. 00 92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	o	348	0	3, 231	74, 882	92. 01
	OTHER REIMBURSABLE COST CENTERS					,,	
	09500 AMBULANCE SERVI CES	0	0	•		12, 351	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118. 00		0	99, 437	О	865, 263	11, 488, 207	
		. '		•			

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

			Т	o 12/31/2023	Date/Time Pre 5/24/2024 9: 2	
Cost Center Description	DATA	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	MAINTENANCE &	i aiii
	PROCESSI NG		OUNTS	ADMI NI STRATI VE	REPAI RS	
			RECEI VABLE	AND GENERAL		
	5. 02	5. 04	5. 05	5. 06	6. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		1, 620		190. 00
191. 00 19100 RESEARCH	0	C	0	2, 019	32, 302	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0		194. 00
194.01 07951 BSU_PHARMACY	0	C) C	0	0	194. 01
194.02 07952 PAVILLION PHARMACY	0	C) C	0		194. 02
194. 03 07953 VENDI NG	0	C) C	0		194. 03
194. 04 07954 CARELI NE	0	C	0	0		194. 04
194. 05 07955 WELLNESS CENTER	0	C	0	170	87, 630	
194.06 07956 PHYSICIAN PRACTICE CLINICS	0	C	0	787	411, 322	•
194. 07 07957 PERINATAL CLINIC	0	C) C	0		194. 07
194. 08 07958 RENTAL PROPERTY	0	C) C	5, 252	1, 277, 721	194. 08
194. 09 07959 ADVERTI SI NG	0	C) C	0	0	194. 09
194. 10 07960 INTEGRA LTAC	0	C) C	389	203, 329	194. 10
194. 11 07961 IU HEALTH HOSPICE	0	C	0	100	52, 529	•
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	C) C	0		194. 12
194. 13 07963 PEDI ATRI C THERAPI ES	0	C) C	0	73, 569	•
194.14 07964 NEW CASTLE ONCOLOGY	0	C	0	0		194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATIONS	0	C	0	73	38, 417	•
194. 16 07966 JAY COUNTY HOSPITAL	0	C	0	2, 581	85, 816	•
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	C) C	0		194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	C	0	0		194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	C	0	0		194. 19
194.20 07970 MEALS ON WHEELS	0	C	0	0		194. 20
194. 21 07971 ST MARY'S SCHOOL	0	C	0	0		194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	0	C	0	1, 164		194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	0	C	0	199	14, 717	
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	C	0	817	427, 214	
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	C	0	1		194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	C	0	1, 903	59, 612	•
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	C	0	0		194. 27
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP	0	C	0	0		194. 28
194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	C	0	0		194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	C	0	0		194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0		194. 31
194. 32 07982 RENAL DI ALYSI S	0	C	0	0		194. 32
194. 33 07983 LAB CORP	0	C	0	0		194. 33
194. 34 07984 H. O. MATERI ALS MGMT	0	C	0	0		194. 34
194. 35 07985 LEASED SPACE	0	C	O C	729	380, 955	1
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	C	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	99, 437	' C	883, 067	14, 633, 340	J202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/24/2024 9:21 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

					12/31/2023	5/24/2024 9: 2	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7. 00	8. 00	9. 00	10.00	11. 00	
4 00	GENERAL SERVI CE COST CENTERS	T					1 00
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						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	1, 676, 225					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	2, 696				8. 00
9. 00	00900 HOUSEKEEPI NG	25, 866	1	451, 933			9. 00
10.00	01000 DI ETARY 01100 CAFETERI A	33, 986	0		593, 733	212 542	10.00
11. 00 13. 00	01300 NURSING ADMINISTRATION	17, 989 19, 906	0	-,	0	313, 543 8, 978	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	43, 448	0		Ö	0,770	14. 00
15. 00	01500 PHARMACY	14, 242	2	4, 768	0	12, 926	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	· ·	0	0	
18. 00 21. 00	01080 PATIENT TRANSPORTATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 509	0	505 0	0	6, 702 449	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	81, 584	1	27, 208	0	1, 782	1
23. 00	02300 PARAMED ED PRGM	319	0		o	523	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	371, 130	1, 338		467, 599	85, 339	1
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	58, 139	213 0	· ·	23, 921	19, 770 0	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	18, 725	23		2, 271	5, 781	1
40.00	04000 SUBPROVI DER - I PF	0	0		. 0	0	1
41. 00	04100 SUBPROVI DER - I RF	20, 868	76		71, 160	5, 249	1
43. 00	04300 NURSERY	10, 542	27	3, 530	0	1, 388	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	71, 927	245	24, 083	ol	19, 886	50.00
51. 00	05100 RECOVERY ROOM	17, 045	113	· ·	Ö	5, 857	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	24, 845	145	· ·	0	6, 603	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	130, 768	121		0	22, 050	1
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 665	0		0	3, 107 0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	29, 292	38		0	5, 9 52	1
60. 00	06000 LABORATORY	37, 815	0		Ö	9, 199	1
60. 01	06001 BLOOD LABORATORY	0	0		0	0	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0 (55	63. 00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	9, 973	0		0	8, 655 1, 588	1
66. 00	06600 PHYSI CAL THERAPY	37, 983	7	4, 167	0	15, 632	1
67. 00	06700 OCCUPATI ONAL THERAPY	5, 053	0	1, 692	0	2, 400	
68. 00	06800 SPEECH PATHOLOGY	1, 209	0	405	0	1, 413	1
68. 01	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	0 34, 274	0 26		0	0 5, 051	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 274	0	0	0	3, 031	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	Ö	Ö	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	7, 205	0	1, 787	0	6, 219	
74. 00 76. 00	07400 RENAL DI ALYSI S 03160 CARDI OPULMONARY	6, 133	/	2, 053 0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	3, 372	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	872	0	0	0	1, 685	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90. 00	09000 CLINIC	0	0	O	0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	13, 411	0		0	1, 430	
90. 02	09002 PAIN CLINIC	47, 170	0	15, 794	0	1, 149	1
90. 03	09003 ONCOLOGY CLINIC	15, 101	65	· ·	0	7, 057	1
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	70, 937	213	23, 751	0	26, 991	91. 00 92. 00
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	9, 111	18	3, 051	o	2, 689	1
01	OTHER REIMBURSABLE COST CENTERS					2,307]
	09500 AMBULANCE SERVICES	1, 503	0		0	0	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118.00		1, 293, 545	2, 679	414, 214	564, 951	306, 872	1
	NONREI MBURSABLE COST CENTERS						
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1, 327	190. 00

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

			To	12/31/2023	Date/Time Pre 5/24/2024 9:2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	alli
oost denter beschiption	PLANT	LINEN SERVICE	HOUSEREEFTING	DI E IANKI	ON ETERIN	
	7. 00	8. 00	9. 00	10.00	11. 00	
191. 00 19100 RESEARCH	3, 930	0		0	2, 271	191. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	ol	0	194. 00
194.01 07951 BSU PHARMACY	0	0	0	o	0	194. 01
194. 02 07952 PAVILLION PHARMACY	0	0	0	o	0	194. 02
194. 03 07953 VENDI NG	0	0	0	o	0	194. 03
194. 04 07954 CARELI NE	0	0	0	o	0	194. 04
194. 05 07955 WELLNESS CENTER	10, 662	17	3, 570	o	0	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	50, 047	0		o		194. 06
194. 07 07957 PERINATAL CLINIC	0	0	0	o	0	194. 07
194. 08 07958 RENTAL PROPERTY	155, 466	0	17, 687	o	0	194. 08
194. 09 07959 ADVERTI SI NG	0	0	0	o	0	194. 09
194. 10 07960 INTEGRA LTAC	24, 740	0	0	28, 782	0	194. 10
194. 11 07961 I U HEALTH HOSPICE	6, 391	0	2, 140	ol	0	194, 11
194. 12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	ol	0	194, 12
194. 13 07963 PEDI ATRI C THERAPI ES	8, 951	0	0	ol	0	194. 13
194. 14 07964 NEW CASTLE ONCOLOGY	0	0	0	ol		194. 14
194. 15 07965 MARKETING/PUBLIC RELATIONS	4, 674	0	0	o	0	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	10, 442	0	3, 496	o		194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	ol		194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	ol	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	o	0	194. 19
194.20 07970 MEALS ON WHEELS	0	0	0	ol	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	ol	0	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	0	0	0	o	0	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	1, 791	0	600	o	91	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	51, 981	0	0	o	0	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0	0	o	0	194. 25
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	7, 253	0	2, 429	o	1, 358	194. 26
194.27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	o	0	194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	o	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	o	0	194. 29
194. 30 07980 CARDINAL HEALTH ALLIANCE	0	0	0	o	0	194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0	194. 31
194. 32 07982 RENAL DIALYSIS	0	0	0	o	0	194. 32
194. 33 07983 LAB CORP	0	0	0	o	0	194. 33
194.34 07984 H.O. MATERIALS MGMT	0	0	0	o	0	194. 34
194. 35 07985 LEASED SPACE	46, 352	0	0	o	0	194. 35
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 676, 225	2, 696	451, 933	593, 733	313, 543	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

				To	12/31/2023	Date/Time Prep 5/24/2024 9: 2	
						OTHER GENERAL SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PATI ENT	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	TRANSPORTATION	
		13.00	14. 00	15. 00	16. 00	18. 00	
1 00	GENERAL SERVICE COST CENTERS					I	1 00
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 5. 05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04 5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A	2/7 222					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	367, 088	772, 993				13. 00 14. 00
15. 00	01500 PHARMACY	0	2, 147				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0		16. 00
18. 00	01080 PATIENT TRANSPORTATION	3, 850	0	0	0	42, 919	18.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	400	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	O	0	0	0	Ö	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	163, 076 43, 465	30, 209	1, 281 854	0		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	43, 465	9, 952 0	0	0	1, 034	32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	12, 776	2, 031	66	0	249	35. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	11, 426 2, 839	640 0	11	0	221	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	2,037	<u> </u>	ı o] 00	43.00
50.00	05000 OPERATING ROOM	14, 127	129, 233	431	0		50.00
51. 00 52. 00	05100 RECOVERY ROOM	14, 138	1, 474	332 178	0		51.00
54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC	12, 782 9, 861	3, 786 20, 837	910	0	4, 595	52. 00 54. 00
57. 00	05700 CT SCAN	0	1, 411	108	0	976	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	7, 318	33, 721	251	0	2, 184 2, 085	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	o	0	O	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	130	63. 00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	11	10, 418	0	0	554	65. 00
66. 00	06600 PHYSI CAL THERAPY		922 485	0	0	153 425	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	4	0	0	129	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1	0	0	76	68. 00
68. 01 69. 00	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	2, 095	308	0 15	0	0 838	68. 01 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	277, 232		0	1, 697	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	227, 497	0	0	2, 651	72. 00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0 20	201, 729 40, 483	0	7, 975 372	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	0	150	40, 403	0	74	74. 00
76. 00	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	345	30	0	0	123	76. 97
76. 98 77. 00	07700 ALLOGENEIC HSCT ACQUISITION	3, 254	4, 445 0	0	0	411	76. 98 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	Ö	0	0	0	Ö	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS					1 0	00.00
90. 00 90. 01	09000 CLINIC 09001 SUBSTANCE ABUSE CLINIC	0 552	0 30	0	0	0	90. 00 90. 01
90. 02	09002 PAIN CLINIC	979	398	3	0	58	90. 02
90. 03	09003 ONCOLOGY CLINIC	9, 823	2, 165		0	884	90. 03
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	49, 306	12, 577	1, 745	0	5, 029	91. 00 92. 00
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	5, 032	258	32	0	148	92. 00 92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0	0	0		95.00
102.00	10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	. 0	0	0	0	1 0	102. 00
113.00	11300 I NTEREST EXPENSE						113. 00
			_	_	_	_	

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			To	12/31/2023	Date/Time Prepared:	:
					5/24/2024 9: 21 am OTHER GENERAL	
					SERVI CE	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PATI ENT	_
oost ochter beschiptron	ADMI NI STRATI ON	SERVICES &	THANWAOT		TRANSPORTATION	
	ADMIT NOT STRUCT FOR	SUPPLY		LI BRARY	THO WAS TON TANK ON	
	13.00	14.00	15. 00	16. 00	18. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	367, 055	772, 781	248, 764	0	42, 919 118. 0)0
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 0)()
191. 00 19100 RESEARCH	0	1	0	0	0 191. 0)()
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194. 0)()
194.01 07951 BSU PHARMACY	0	0	0	0	0 194. 0)1
194.02 07952 PAVILLION PHARMACY	22	59	34, 980	0	0 194. 0)2
194. 03 07953 VENDI NG	0	0	0	0	0 194. 0)3
194. 04 07954 CARELI NE	0	0	0	0	0 194. 0)4
194. 05 07955 WELLNESS CENTER	0	0	0	0	0 194. 0)5
194.06 07956 PHYSICIAN PRACTICE CLINICS	0	0	0	0	0 194. 0)6
194. 07 07957 PERINATAL CLINIC	0	0	0	0	0 194. 0)7
194.08 07958 RENTAL PROPERTY	0	10	0	0	0 194. 0)8
194. 09 07959 ADVERTI SI NG	0	0	0	0	0 194. 0)9
194. 10 07960 I NTEGRA LTAC	0	0	0	0	0 194. 1	10
194. 11 07961 I U HEALTH HOSPI CE	0	0	0	0	0 194. 1	11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0 194. 1	12
194. 13 07963 PEDI ATRI C THERAPI ES	0	142	0	0	0 194. 1	13
194.14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0 194. 1	14
194. 15 07965 MARKETING/PUBLIC RELATIONS	0	0	0	0	0 194. 1	15
194. 16 07966 JAY COUNTY HOSPITAL	0	0	0	0	0 194. 1	16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	0	0 194. 1	17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0 194. 1	18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0	0 194. 1	19
194.20 07970 MEALS ON WHEELS	0	0	0	0	0 194. 2	20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0	0 194. 2	21
194.22 07972 THERAPIES TO OTHER ENTITIES	11	0	0	0	0 194. 2	22
194. 23 07973 CANCER CENTER BOUTIQUE	0	0	0	0	0 194. 2	23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0	0	0	0 194. 2	24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0	0	0	0 194. 2	25
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0	0	0	0 194. 2	26
194.27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0 194. 2	27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0 194. 2	28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0 194. 2	29
194. 30 07980 CARDINAL HEALTH ALLIANCE	0	0	0	0	0 194. 3	30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194. 3	31
194. 32 07982 RENAL DIALYSIS	0	0	0	0	0 194. 3	32
194. 33 07983 LAB CORP	0	0	0	0	0 194. 3	33
194.34 07984 H.O. MATERIALS MGMT	0	0	0	0	0 194. 3	34
194.35 07985 LEASED SPACE	0	0	0	o	0 194. 3	35
200.00 Cross Foot Adjustments					200. 0)()
201.00 Negative Cost Centers	0	0	0	0	0 201. 0)()
202.00 TOTAL (sum lines 118 through 201)	367, 088	772, 993	283, 744	0	42, 919 202. 0)0

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Pa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

				To	12/31/2023	Date/Time Pre 5/24/2024 9: 2	
		INTERNS &	RESI DENTS			0,2,,202,,,2	
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	oost center bescriptron	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	Residents Cost	
						& Post	
						Stepdown Adjustments	
		21.00	22. 00	23. 00	24. 00	25. 00	
1 00	GENERAL SERVICE COST CENTERS					ı	1 00
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 5. 05	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						5. 04
5. 05	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 05 5. 06
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
18. 00	01080 PATIENT TRANSPORTATION						18. 00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	10, 537	1, 416, 243				21. 00 22. 00
23. 00	02300 PARAMED ED PRGM		1, 410, 243	6, 773			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			-,			
30.00	03000 ADULTS & PEDIATRICS				7, 302, 158		30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T				1, 136, 572 0	0	31. 00 32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT				354, 977	Ö	35. 00
40. 00	04000 SUBPROVI DER - I PF				0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF				456, 222		41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				188, 039	0	43. 00
50.00	05000 OPERATING ROOM				1, 458, 982	0	50.00
51.00	05100 RECOVERY ROOM				326, 446		51.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC				467, 104 2, 368, 683		52. 00 54. 00
57. 00	05700 CT SCAN				78, 185		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)				0	0	58. 00
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY				572, 677 708, 094	0	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY				700, 094	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.				3, 750	0	63. 00
65. 00	06500 RESPI RATORY THERAPY				208, 134		65. 00
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY				5, 308 684, 097	0	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY				93, 585		67. 00
68. 00	06800 SPEECH PATHOLOGY				24, 697	0	68. 00
68. 01 69. 00	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY				0 609, 336	0	68. 01 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				314, 565		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT				265, 200	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS				349, 782		73. 00
73. 01 74. 00	07301 HOSPITAL BASED RETAIL PHARMACIES 07400 RENAL DIALYSIS				222, 584 109, 596		73. 01 74. 00
76. 00	03160 CARDI OPULMONARY				0	Ö	76. 00
76. 97	07697 CARDIAC REHABILITATION				7, 995	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY				30, 494	0	76. 98
77. 00 78. 00	O7700 ALLOGENEI C HSCT ACQUISITION O7800 CAR T-CELL IMMUNOTHERAPY				0	0	77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS						70.00
90. 00	09000 CLI NI C				0	0	90.00
90. 01 90. 02	O9001 SUBSTANCE ABUSE CLINIC O9002 PAIN CLINIC				234, 756		90. 01 90. 02
90. 02	09003 ONCOLOGY CLINIC				816, 730 294, 893	l e e e e e e e e e e e e e e e e e e e	90.02
91. 00	09100 EMERGENCY				1, 380, 125		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92. 01	O9201 OBSERVATI ON BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				169, 266	0	92. 01
95. 00	09500 AMBULANCE SERVICES				25, 891	0	95. 00
	10200 OPI OI D TREATMENT PROGRAM				0		102. 00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od:	Worksheet B	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
	INTERNS &	RESI DENTS			372472024 7.2	i dili
	TIVIENNO W	RESIDENTS				
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
oust deliter bescription	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	Residents Cost	
	I W I KI NOLO	1 KGW 00313	1 IXOW		& Post	
					Stepdown	
					Adjustments	
	21. 00	22. 00	23. 00	24.00	25. 00	
SPECIAL PURPOSE COST CENTERS	21.00	22.00	23.00	24.00	23.00	
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 21, 268, 923	0	118. 00
NONREI MBURSABLE COST CENTERS	U	U		0 21, 200, 723	0	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				3, 182		190. 00
191. 00 19100 RESEARCH				72, 487		191. 00
				72, 467		194. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS				0		1
194. 01 07951 BSU PHARMACY				25 0/1		194. 01
194. 02 07952 PAVILLION PHARMACY				35, 061		194. 02
194. 03 07953 VENDI NG				0		194. 03
194. 04 07954 CARELI NE				100 711		194. 04
194. 05 07955 WELLNESS CENTER				183, 716		194. 05
194. 06 07956 PHYSI CI AN PRACTI CE CLINI CS				851, 971		194. 06
194. 07 07957 PERI NATAL CLI NI C				0		194. 07
194. 08 07958 RENTAL PROPERTY				2, 646, 916		194. 08
194. 09 07959 ADVERTI SI NG				0		194. 09
194. 10 07960 I NTEGRA LTAC				446, 734		194. 10
194. 11 07961 I U HEALTH HOSPI CE				110, 115		194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS				0		194. 12
194. 13 07963 PEDI ATRI C THERAPI ES				151, 257		194. 13
194.14 07964 NEW CASTLE ONCOLOGY				0		194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS				78, 967		194. 15
194. 16 07966 JAY COUNTY HOSPITAL				184, 452		194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE				0		194. 17
194.18 07968 CHV CARDINAL HEALTH VENTURES				0		194. 18
194. 19 07969 HEALTH CARE CONNECTIONS				0	0	194. 19
194.20 07970 MEALS ON WHEELS				0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL				0	0	194. 21
194.22 07972 THERAPIES TO OTHER ENTITIES				1, 724	0	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE				31, 129	0	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY				878, 157	0	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH				1	0	194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL				128, 487	0	194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES				0	0	194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP				0	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI				0		194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE				0		194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS				0	l .	194. 31
194. 32 07982 RENAL DI ALYSI S				0		194. 32
194. 33 07983 LAB CORP				0		194. 33
194. 34 07984 H. O. MATERI ALS MGMT				0		194. 34
194. 35 07985 LEASED SPACE				783, 069		194. 35
200.00 Cross Foot Adjustments	10, 537	1, 416, 243	6, 77			200. 00
201.00 Negative Cost Centers	10, 537	1,410,243		0 1, 433, 553		201.00
202.00 TOTAL (sum lines 118 through 201)	10, 537	1, 416, 243				201.00
202. 00 TOTAL (Sum TITIES TTO THE OUGH 201)	10, 337	1,410,243	I 0, 77	27, 207, 701	1	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 9: 21 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

				5/24/2024 9: 21	<u>am</u>
		Cost Center Description	Total		
			26. 00		
		AL SERVICE COST CENTERS			
1.00	1 1	NEW CAP REL COSTS-BLDG & FIXT			1. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 01	1 1	COMMUNI CATI ONS			5. 01
5. 02	1 1	DATA PROCESSING			5. 02
5.04	1 1	ADMITTING			5. 04
5.05	1 1	CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5.06	1 1	OTHER ADMINISTRATIVE AND GENERAL			5. 06
6.00		MAINTENANCE & REPAIRS OPERATION OF PLANT			6.00
7.00	1 1	4			7. 00
8.00	1 1	LAUNDRY & LINEN SERVICE			8. 00
9.00		HOUSEKEEPI NG DI ETARY			9.00
10.00	1 1		•		10. 00 11. 00
11. 00 13. 00	1 1	CAFETERIA NURSING ADMINISTRATION	ł		13. 00
14. 00	1 1	CENTRAL SERVICES & SUPPLY			14. 00
15. 00		PHARMACY			15. 00
16. 00	1 1	MEDICAL RECORDS & LIBRARY			16. 00
18. 00		PATIENT TRANSPORTATION			18. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD			21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
23. 00		PARAMED ED PRGM			23. 00
20.00		ENT ROUTINE SERVICE COST CENTERS			20.00
30. 00		ADULTS & PEDI ATRI CS	7, 302, 158		30. 00
31. 00	1 1	INTENSIVE CARE UNIT	1, 136, 572		31. 00
32. 00	1 1	CORONARY CARE UNIT	0		32. 00
35. 00		NEONATAL INTENSIVE CARE UNIT	354, 977		35. 00
40. 00	1 1	SUBPROVI DER - I PF	0		40. 00
41. 00	1 1	SUBPROVI DER - I RF	456, 222		41. 00
43. 00	1 1	NURSERY	188, 039		43. 00
		ARY SERVICE COST CENTERS			
50.00		OPERATI NG ROOM	1, 458, 982		50.00
51.00	1 1	RECOVERY ROOM	326, 446		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	467, 104		52.00
54.00	1 1	RADI OLOGY-DI AGNOSTI C	2, 368, 683		54.00
57.00	05700	CT SCAN	78, 185		57.00
58.00	1 1	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	572, 677		59.00
60.00	06000	LABORATORY	708, 094		60.00
60. 01	06001	BLOOD LABORATORY	0		60. 01
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	3, 750		63.00
65.00	06500	RESPI RATORY THERAPY	208, 134		65.00
65. 01	06501	SLEEP LAB	5, 308		65. 01
66.00	06600	PHYSI CAL THERAPY	684, 097		66.00
67.00	06700	OCCUPATI ONAL THERAPY	93, 585		67.00
68. 00	06800	SPEECH PATHOLOGY	24, 697		68.00
68. 01	06801	AUDI OLOGY	0		68. 01
69. 00	06900	ELECTROCARDI OLOGY	609, 336		69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	314, 565		71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	265, 200		72.00
73. 00		DRUGS CHARGED TO PATIENTS	349, 782		73. 00
73. 01		HOSPITAL BASED RETAIL PHARMACIES	222, 584		73. 01
74. 00		RENAL DI ALYSI S	109, 596		74. 00
76.00		CARDI OPULMONARY	0		76.00
76. 97		CARDI AC REHABI LI TATI ON	7, 995		76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	30, 494		76. 98
77. 00	1 1	ALLOGENEIC HSCT ACQUISITION	0		77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0		78. 00
00 00		TIENT SERVICE COST CENTERS CLINIC	ما		00 00
90. 00 90. 01		SUBSTANCE ABUSE CLINIC	224 756		90. 00 90. 01
		PAIN CLINIC	234, 756 816, 730		90. 01 90. 02
90. 02 90. 03		ONCOLOGY CLINIC	294, 893		90. 02 90. 03
90.03		EMERGENCY EINIC	1, 380, 125		90. 03
91.00		OBSERVATION BEDS (NON-DISTINCT PART)	1, 300, 125		91.00
92. 00	1 1	OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	169, 266		92. 00 92. 01
72. UI		REIMBURSABLE COST CENTERS	107, 200		72. UI
95 00		AMBULANCE SERVICES	25, 891		95. 00
		OPIOID TREATMENT PROGRAM	25, 891		95. 00 102. 00
102.00		L PURPOSE COST CENTERS	U _I		102.00
113 00		INTEREST EXPENSE	I		113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21, 268, 923		118. 00
		MBURSABLE COST CENTERS	21,200,723		. 10. 00
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 182		190. 00
		RESEARCH	72, 487		191. 00
			.2, 101	I	

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Pa

		5/24/2024 9: 21 am
Cost Center Description	Total	
·	26.00	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	194. 00
194.01 07951 BSU PHARMACY	o	194. 01
194.02 07952 PAVILLION PHARMACY	35, 061	194. 02
194. 03 07953 VENDI NG	O	194. 03
194. 04 07954 CARELI NE	0	194. 04
194. 05 07955 WELLNESS CENTER	183, 716	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	851, 971	194. 06
194. 07 07957 PERI NATAL CLI NI C	0	194. 07
194. 08 07958 RENTAL PROPERTY	2, 646, 916	194. 08
194. 09 07959 ADVERTI SI NG	0	194. 09
194. 10 07960 INTEGRA LTAC	446, 734	194. 10
194. 11 07961 IU HEALTH HOSPICE	110, 115	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	194. 12
194. 13 07963 PEDIATRIC THERAPIES	151, 257	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	194. 14
194. 15 07965 MARKETI NG/PUBLIC RELATIONS	78, 967	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	184, 452	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	194. 19
194.20 07970 MEALS ON WHEELS	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	1, 724	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	31, 129	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	878, 157	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	1	194. 25
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	128, 487	194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	194. 29
194.30 07980 CARDINAL HEALTH ALLIANCE	0	194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	194. 31
194. 32 07982 RENAL DI ALYSI S	0	194. 32
194. 33 07983 LAB CORP	0	194. 33
194.34 07984 H.O. MATERIALS MGMT	O	194. 34
194. 35 07985 LEASED SPACE	783, 069	194. 35
200.00 Cross Foot Adjustments	1, 433, 553	200. 00
201.00 Negative Cost Centers	O	201. 00
202.00 TOTAL (sum lines 118 through 201)	29, 289, 901	202.00

	Financial Systems	BALL MEMORIAL		ON 45 0000 D		U OT FORM CMS-	
COST	ALLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2023	Worksheet B-1	
				Т	o 12/31/2023	Date/Time Pre 5/24/2024 9:2	
		CAPI TAL				0,21,2021 ,12	
		RELATED COSTS	EMBL 0./EE		5474	45.00	
	Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFITS	COMMUNI CATI ONS	DATA PROCESSI NG	ADMITTING (GROSS	
		(SQUARE	DEPARTMENT	(FTE' S)	(GROSS	CHARGES)	
		FEET)	(GROSS	(112 3)	CHARGES)	OTIANOES)	
		,	SALARI ES)				
	CENEDAL CEDIALCE COCT CENTEDO	1.00	4. 00	5. 01	5. 02	5. 04	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1, 819, 433					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 136	134, 641, 460				4. 00
5. 01	01160 COMMUNI CATI ONS	1, 822	669, 980				5. 01
5.02	00550 DATA PROCESSING	0	0	0	2, 464, 468, 227		5. 02
5.04	00570 ADMITTING	6, 030	3, 214, 192	4, 721	0	2, 464, 468, 227	5. 04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMINI STRATI VE AND GENERAL	54, 669	4, 643, 859	4, 191	0	0	5. 05 5. 06
6. 00	00600 MAINTENANCE & REPAIRS	905, 632	2, 707, 166			0	
7.00	00700 OPERATION OF PLANT	49, 613	1, 508, 112			0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1		0	
9.00	00900 HOUSEKEEPI NG	12, 307	3, 586, 355			0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	16, 170 8, 559	2, 153, 153 837, 109			0	10.00
13. 00	01300 NURSING ADMINISTRATION	9, 471	4, 188, 568			0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	20, 672	0	0		0	14. 00
15. 00	01500 PHARMACY	6, 776	6, 238, 721			0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1 000 000	0	_	0	16.00
18. 00 21. 00	01080 PATIENT TRANSPORTATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	718	1, 892, 223 81, 166			0	18. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	38, 817	457, 853			0	22. 00
23. 00	02300 PARAMED ED PRGM	152	218, 362			0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	176, 579 27, 662	29, 943, 265 7, 887, 508				1
32. 00	03200 CORONARY CARE UNIT	27,002	7, 667, 506	9, 3/4		60, 827, 055 0	32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	8, 909	2, 280, 348	1		14, 653, 983	
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	9, 929	1, 977, 125				1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	5, 016	502, 076	658	3, 516, 138	3, 516, 138	43. 00
50.00	05000 OPERATI NG ROOM	34, 222	6, 503, 083	9, 429	240, 203, 943	240, 203, 943	50.00
51. 00	05100 RECOVERY ROOM	8, 110	2, 159, 207			33, 076, 241	
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	11, 821 62, 218	2, 678, 933 8, 881, 726				
57. 00	05700 CT SCAN	1, 744	1, 408, 976			270, 311, 674 57, 392, 281	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	l
59. 00	05900 CARDI AC CATHETERI ZATI ON	13, 937	2, 448, 996	2, 822	128, 463, 185	128, 463, 185	59. 00
60.00	06000 LABORATORY	17, 992	1, 476			122, 622, 894	1
60. 01 63. 00	06001 BLOOD LABORATORY	0	0	0	_	7 647 250	1
65.00	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	4, 745	3, 352, 581	4, 104	7, 647, 350 32, 576, 084	7, 647, 350 32, 576, 084	
65. 01	06501 SLEEP LAB	0	501, 746			9, 008, 836	65. 01
66. 00	06600 PHYSI CAL THERAPY	18, 072	5, 828, 858			24, 990, 967	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 404	935, 593	1		7, 595, 158	1
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 AUDI OLOGY	575	585, 757	670		4, 460, 826 0	
69. 00	06900 ELECTROCARDI OLOGY	16, 307	1, 705, 809	1		49, 283, 823	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		99, 845, 529	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	,,	155, 942, 276	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2 002 401	0	409, 017, 958	409, 017, 958	
73. 01 74. 00	07301 HOSPITAL BASED RETAIL PHARMACIES 07400 RENAL DIALYSIS	3, 428 2, 918	3, 093, 691	2, 949	21, 891, 431 4, 331, 344	21, 891, 431 4, 331, 344	
76. 00	03160 CARDI OPULMONARY	2, 710	0	o o	0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 052, 961	1, 599	7, 221, 569	7, 221, 569	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	415	677, 406	799	24, 186, 899	24, 186, 899	
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
76.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	ı o	0	,ı <u> </u>	0	0	78.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	6, 381	431, 913	1		741, 027	
90. 02	09002 PAIN CLINIC	22, 443	335, 276	1		3, 406, 435	
90. 03 91. 00	09003 ONCOLOGY CLINIC 09100 EMERGENCY	7, 185 33, 751	2, 818, 281 9, 759, 835			52, 011, 215 295, 798, 266	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,731	.,,.		_:5,7,5,250	5, , ,5, 250	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	4, 335	951, 005	1, 275	8, 693, 279	8, 693, 279	
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	715		1 0		^	95. 00
95. 00 102. 00	09500 AMBULANCE SERVICES 10200 OPIOLD TREATMENT PROGRAM	715	0				102.00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<u>, </u>			<u>, </u>		

<u>leaith</u> Finan	cial Systems	BALL MEMORIA	_ HOSPI TAL		In_Lie	u of Form CMS-2	<u> 2552-10</u>
	TION - STATISTICAL BASIS		Provi der Co	CN: 15-0089 F	Peri od:	Worksheet B-1	
				F	From 01/01/2023 o 12/31/2023	D-+- /T: D	
					0 12/31/2023	Date/Time Pre 5/24/2024 9: 2	
		CAPI TAL				3/24/2024 7.2	1 dill
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	COMMUNI CATI ONS	DATA	ADMITTI NG	
	oust content beschipthon	FIXT	BENEFITS	Commont of the	PROCESSI NG	(GROSS	
		(SQUARE	DEPARTMENT	(FTE' S)	(GROSS	CHARGES)	
		FEET)	(GROSS	(112 3)	CHARGES)	OTIMICOES)	
		'''	SALARI ES)		OTH MOLO)		
		1.00	4.00	5. 01	5. 02	5. 04	
SPECI	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						1113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 637, 357	131, 100, 250	178, 007	2, 464, 468, 227	2. 464. 468. 227	118.00
	IMBURSABLE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,			1
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	267, 508	629	0	0	190. 00
191. 00 19100		1, 870	742, 678				191. 00
	OTHER NONREIMBURSABLE COST CENTERS	1,0,0	, 12, 0, 0	1,0,,) o		194. 00
	BSU PHARMACY	ا	0) o		194. 01
	PAVILLION PHARMACY		0				194. 02
194. 02 07 952 194. 03 07953			0				194. 02
194. 03 07 953 194. 04 07954			0				194. 04
	WELLNESS CENTER	5, 073	0				194. 04
		1	0				194. 05
	PHYSICIAN PRACTICE CLINICS	23, 812	0				
	PERINATAL CLINIC	72.0(0	0				194. 07
	RENTAL PROPERTY	73, 969	0		0		194. 08
1	ADVERTI SI NG	0	0		0		194. 09
	INTEGRA LTAC	11, 771	0		0		194. 10
	IU HEALTH HOSPICE	3, 041	0	0	0		194. 11
	POB MEDICAL PAVILLION CONDOS	0	0	C	0		194. 12
	PEDIATRIC THERAPIES	4, 259	65, 364	[C	0		194. 13
	NEW CASTLE ONCOLOGY	0	0	C	0		194. 14
	MARKETING/PUBLIC RELATIONS	2, 224	0	C	0		194. 15
	JAY COUNTY HOSPITAL	4, 968	788, 110	770	0		194. 16
	CARDI NAL HEALTH CHOI CE	0	0	(0		194. 17
	CHV CARDINAL HEALTH VENTURES	0	0	(0		194. 18
	HEALTH CARE CONNECTIONS	0	0	C	0		194. 19
194. 20 07970	MEALS ON WHEELS	0	0	C	0	0	194. 20
194. 21 07971	ST MARY'S SCHOOL	0	0	C	0	0	194. 21
194. 22 07972	THERAPIES TO OTHER ENTITIES	0	1, 109, 800	C	0	0	194. 22
194. 23 07973	CANCER CENTER BOUTIQUE	852	16, 900	43	0	0	194. 23
194. 24 07974	BOSC BALL OUTPATIENT SURGERY	24, 732	0	C	0	0	194. 24
194. 25 07975	CARDI NAL BEHAVI ORAL HEALTH	0	450	C	0	0	194. 25
194. 26 07976	BLACKFORD COMMUNITY HOSPITAL	3, 451	550, 400	644	0	0	194. 26
194. 27 07977	MIDWEST HEALTH STRATEGIES	0	0	C	0	0	194. 27
194. 28 07978	CARDINAL SELECT RISK RETENTION GRP	0	0	C	0	0	194. 28
194. 29 07979	HOME OFFICE CARDINAL HEALTH INITIATI	0	0	(0	0	194. 29
194. 30 07980	CARDINAL HEALTH ALLIANCE	O	0	C	0	0	194. 30
194. 31 07986	OTHER NONREIMBURSABLE COST CENTERS	o	0	l c	0	0	194. 31
194. 32 07982	RENAL DIALYSIS	o	0		0	0	194. 32
194. 33 07983		o	0		0		194. 33
	H. O. MATERIALS MGMT		0	Ì	ol		194. 34
	LEASED SPACE	22, 054	0		ol ŏ		194. 35
200. 00	Cross Foot Adjustments	22,004	O				200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	29, 289, 901	24, 092, 988	885, 129	18, 810, 357	15, 931, 592	
202.00	Part I)	27, 207, 701	27,072,700	003, 129	10, 010, 337	15, 751, 572	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	16. 098367	0. 178942	4. 885627	0. 007633	0. 006465	203 00
204. 00	Cost to be allocated (per Wkst. B,	10.070307	66, 583			99, 437	
207.00	Part II)		00, 303	27,003	ή	77, 437	207.00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000495	0. 163730	0. 000000	0. 000040	205 00
200.00			0.000470	0. 103/30	J. 000000	0.000040	200.00
	NAHE adjustment amount to be allocated						206. 00
206 001		i I		1	1		1-00.00
206. 00	1]					
206. 00 207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00

Heal th	Financial Systems	BALL MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre	pared:
	Cost Center Description	CASHI ERI NG/ACCR OUNTS RECEI VABLE	econciliation	OTHER ADMINISTRATIV AND GENERAL	MAINTENANCE &	5/24/2024 9: 2 OPERATION OF PLANT (SQUARE	1 am
		(GROSS		(ACCUM.	FEET)	FEET)	
		CHARGES) 5. 05	5A. 06	COST) 5. 06	6. 00	7. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 01 5. 02 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00	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	2, 464, 468, 227 0 0 0 0	-41, 073, 020 0 0 0	430, 390, 51 25, 339, 71 9, 447, 84 1, 314, 07	5 847, 144 7 49, 613	797, 531 0	4. 00 5. 01 5. 02 5. 04 5. 05 5. 06 6. 00 7. 00
9.00	00900 HOUSEKEEPI NG	0	0	5, 889, 93		12, 307	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	0	3, 371, 47 1, 502, 24			1
13. 00	01300 NURSING ADMINISTRATION	0	0	6, 189, 58	5 9, 471	9, 471	13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0	12, 246, 39 9, 472, 38			1
16. 00	01600 MEDICAL RECORDS & LIBRARY	Ö	0		0	0	16. 00
18. 00 21. 00	01080 PATIENT TRANSPORTATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2, 404, 40 4, 879, 57		718 0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	o	0	4, 628, 84	4 38, 817	38, 817	22. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	293, 36	4 152	152	23. 00
30. 00	03000 ADULTS & PEDIATRICS	272, 216, 133	0	62, 384, 27	4 176, 579	176, 579	30. 00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	60, 827, 055	0	14, 009, 34	6 27, 662	27, 662 0	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	14, 653, 983	0	3, 561, 80	1 8, 909	-	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	13, 004, 438	0	3, 082, 53	0 1 9, 929	0 9, 929	40. 00 41. 00
43. 00	04300 NURSERY	3, 516, 138	0	858, 06		'	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	240, 203, 943	0	18, 779, 67	0 34, 222	34, 222	50.00
51. 00	05100 RECOVERY ROOM	33, 076, 241	0	3, 763, 41			1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	29, 529, 990 270, 311, 674	0	6, 058, 31 21, 113, 14		11, 821 62, 218	1
57. 00	05700 CT SCAN	57, 392, 281	0	3, 048, 79			1
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 128, 463, 185	0	5, 942, 08	0 2 13, 937	0 13, 937	
60.00	06000 LABORATORY	122, 622, 894	0	19, 690, 16			
60. 01	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	7 647 350	0	1 414 00	0	0	60. 01 63. 00
	06500 RESPIRATORY THERAPY	7, 647, 350 32, 576, 084	0	1, 614, 90 6, 431, 83			65. 00
	06501 SLEEP LAB	9, 008, 836 24, 990, 967	0				65. 01
66. 00 67. 00		7, 595, 158	0	8, 381, 19 1, 524, 37			66. 00 67. 00
68.00	06800 SPEECH PATHOLOGY	4, 460, 826	0	889, 72	2 575	575	
68. 01 69. 00	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	49, 283, 823	0	3, 823, 97	5 16, 307	0 16, 307	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	99, 845, 529	0	15, 420, 23		0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	155, 942, 276 409, 017, 958	0	14, 042, 12 59, 872, 91		0	72. 00 73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	21, 891, 431	0	23, 980, 75			73. 01
74. 00 76. 00	07400 RENAL DI ALYSI S 03160 CARDI OPULMONARY	4, 331, 344	0	1, 765, 30	6 2, 918 0 0	2,918	74. 00 76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	7, 221, 569	0	1, 488, 03		0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY 07700 ALLOGENEI C HSCT ACQUISITION	24, 186, 899	0	2, 214, 23	4 415 0 0	0	76. 98 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0		0 0	0	90.00
90. 01 90. 02	09001 SUBSTANCE ABUSE CLINIC	741, 027	0	744, 16			1
90. 02	09002 PAIN CLINIC 09003 ONCOLOGY CLINIC	3, 406, 435 52, 011, 215	0	885, 75 5, 170, 17			1
91.00	09100 EMERGENCY	295, 798, 266	0	21, 674, 48	6 33, 751	33, 751	1
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	8, 693, 279	0	1, 574, 39	0 4, 335	4, 335	92. 00 92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES 10200 OPI OI D TREATMENT PROGRAM	0	0		0 715 0 0		95. 00 102. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE	<u> </u>			<u> </u>		113. 00

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 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 9:21 am Cost Center Description CASHIERING/ACC Reconciliation OTHER MAINTENANCE & OPERATION OF ADMI NI STRATI VE REPAI RS OUNTS PLANT RECEI VABLE AND GENERAL (SQUARE (SQUARE (GROSS (ACCUM. FFFT) FEET) CHARGES) COST) 5.05 5A. 06 5.06 6.00 7.00 421, 714, 352 SUBTOTALS (SUM OF LINES 1 through 117) 2,464,468,227 -41, 073, 020 665, 068 615, 455 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 789, 339 n 190.00 0 1, 870 191. 00 191. 00 19100 RESEARCH 983, 926 1, 870 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 000000000000 0 0 194. 01 07951 BSU PHARMACY 0 194. 01 0 0 0 194. 02 07952 PAVILLION PHARMACY 0 194. 02 0 0 194. 03 07953 VENDI NG C 0 0 0 194. 03 194. 04 07954 CARELI NE 0 194. 04 194. 05 07955 WELLNESS CENTER 0 5.073 5, 073 194, 05 82 696 23, 812 194. 06 194.06 07956 PHYSICIAN PRACTICE CLINICS C 383, 334 23, 812 194. 07 07957 PERINATAL CLINIC 0 194. 07 194. 08 07958 RENTAL PROPERTY 0 2, 559, 288 73, 969 73, 969 194. 08 194. 09 07959 ADVERTI SI NG 0 194 09 Ω 194. 10 07960 INTEGRA LTAC C 189, 494 11,771 11, 771 194. 10 194. 11 07961 I U HEALTH HOSPICE 0000000000000000000000000 3, 041 194. 11 C 48, 955 3,041 194. 12 07962 POB MEDICAL PAVILLION CONDOS 0 194, 12 194. 13 07963 PEDI ATRI C THERAPI ES 122, 768 0 4, 259 4, 259 194. 13 194. 14 07964 NEW CASTLE ONCOLOGY 0 194. 14 C C 194. 15 07965 MARKETING/PUBLIC RELATIONS 35, 803 2, 224 2, 224 194. 15 0 194. 16 07966 JAY COUNTY HOSPITAL 1, 257, 803 4, 968 194. 16 0 4.968 194. 17 07967 CARDI NAL HEALTH CHOICE 0 C 0 194. 17 194. 18 07968 CHV CARDI NAL HEALTH VENTURES 0 194. 18 194. 19 07969 HEALTH CARE CONNECTIONS 0 0 0 0 194. 19 194. 20 07970 MEALS ON WHEELS 0 0 0 194 20 Ω 194. 21 07971 ST MARY'S SCHOOL 0 0 194. 21 194. 22 07972 THERAPIES TO OTHER ENTITIES 0 0 194. 22 567, 455 194. 23 07973 CANCER CENTER BOUTIQUE 97, 110 852 194. 23 0 852 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 24, 732 194. 24 398, 145 Ω 24.732 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 0 565 0 194. 25 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 3, 451 194. 26 927, 217 3, 451 194. 27 07977 MI DWEST HEALTH STRATEGIES 0 0 194. 27 0 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 194. 28 0 0 0 194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI 0 194. 29 194. 30 07980 CARDI NAL HEALTH ALLI ANCE 0 0 194. 30 0 0 194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS 0 0 194, 31 0 0 194. 32 07982 RENAL DIALYSIS 0 0 0 0 194. 32 194. 33 07983 LAB CORP 0 0 0 0 0 194. 33 194. 34 07984 H. O. MATERIALS MGMT 0 0 194. 34 194. 35 07985 LEASED SPACE 0 355, 033 22, 054 22, 054 194. 35 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 11, 975, 118 202. 00 202.00 Cost to be allocated (per Wkst. B, 11, 502, 487 41, 073, 020 27, 757, 935 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.004667 0.095432 32. 766490 15. 015238 203. 00 204.00 Cost to be allocated (per Wkst. B, 1, 676, 225 204. 00 883, 067 14, 633, 340 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.002052 2. 101768 205. 00 17. 273734 II)

206. 00

207.00

206.00

207.00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

	Financial Systems	BALL MEMORIA				u of Form CMS-	
COST	ALLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/24/2024 9: 2 NURSI NG	ı am
	oost contor bescription	LINEN SERVICE		(MEALS		ADMI NI STRATI ON	
		(POUNDS OF	HOUSEKEEPI NG)	SERVED)		,	
		LAUNDRY)				(DI RECT NURS.	
		8. 00	9. 00	10. 00	11.00	HRS.) 13. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	100	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	O1160 COMMUNI CATI ONS O0550 DATA PROCESSI NG						5. 01 5. 02
5. 04	00570 ADMITTING						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6. 00 7. 00	OO6OO MAI NTENANCE & REPAI RS OO7OO OPERATI ON OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 254, 701					8.00
9.00	00900 HOUSEKEEPI NG	384	642, 199				9. 00
10.00	01000 DI ETARY	0	16, 170				10. 00
11.00	01100 CAFETERI A	0	8, 559			l	11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	0	9, 471 20, 672		.,	67, 117 0	
15. 00	01500 PHARMACY	746			-	l	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	C	0	0	16. 00
18. 00	01080 PATIENT TRANSPORTATION	0	718	C	-,	l e	
	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0		1	l	
22. 00 23. 00	02200 1 &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	289 18				l	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	10	102		, 240		25.00
30.00	03000 ADULTS & PEDIATRICS	622, 545	176, 994	184, 898	40, 464	29, 816	30.00
31.00	03100 I NTENSI VE CARE UNI T	99, 075	27, 662	9, 459		l	1
32. 00 35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	10, 591	0 8, 909	898 	-	0 2, 336	32. 00 35. 00
40. 00	04000 SUBPROVI DER – I PF	10, 591	0, 909	090		2, 330	40.00
41. 00	04100 SUBPROVI DER - I RF	35, 460	9, 929	28, 138	2, 489	1	ł
43.00	04300 NURSERY	12, 527	5, 016	C	658	519	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	112 012	24 222		0.420	2 502	
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	113, 812 52, 797				2, 583 2, 585	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	67, 682			-,	2, 337	ı
54.00	05400 RADI OLOGY-DI AGNOSTI C	56, 369		C		l	
57. 00	05700 CT SCAN	0	1, 744	C	.,	l	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	17, 604	0 13, 937	(0 2, 822	0 1, 338	
60. 00	06000 LABORATORY	51	17, 820				ı
60. 01	06001 BLOOD LABORATORY	0	0	d	0	Ō	1
	06300 BLOOD STORING, PROCESSING, & TRANS.	0		C			
	06500 RESPIRATORY THERAPY	65	4, 745	(.,	l e	65. 00
66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	3, 076	5, 922		753 7, 412	l e	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	3,070	2, 404		1, 138	l e	67.00
68. 00	06800 SPEECH PATHOLOGY	0	575	C	670	l e	68. 00
68. 01	06801 AUDI OLOGY	0	0	C	0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	12, 129	16, 307		2, 395	l	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö		o o	ő	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	0	2, 540	C	2, 949	0	
74.00	1 1	3, 440	2, 918	C	0	0	
76. 00 76. 97	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	217	0		0 1, 599	0 63	
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY	217	0		799		1
77. 00		0	o	d	0	i	ı
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90. 00 90. 01	09000 CLINIC 09001 SUBSTANCE ABUSE CLINIC	0	0 6, 381			l	
90. 02	09002 PAIN CLINIC	0	22, 443		545	l	ı
90. 03	09003 ONCOLOGY CLINIC	30, 314	7, 185	C	3, 346	1, 796	
91.00	09100 EMERGENCY	99, 328	33, 751	C	12, 798	9, 015	
92. 00 92. 01	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O9201 OBSERVATION BEDS (DISTINCT PART)	0 400	4 225	,	1 275	920	92. 00 92. 01
92. UT	OTHER REIMBURSABLE COST CENTERS	8, 409	4, 335		1, 275	1 920	92.01
95. 00	09500 AMBULANCE SERVICES	0	715	C	0	0	95. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C			102. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
113.00	11300 INTEREST EXPENSE	1	<u> </u>	I	<u> </u>	l	113. 00

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

			То	12/31/2023	Date/Time Prepared: 5/24/2024 9:21 am
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG
oust defined beschiptron		(SQUARE FEET -		(FTE'S)	ADMI NI STRATI ON
	(POUNDS OF	HOUSEKEEPI NG)	SERVED)		
	LAUNDRY)	,	·		(DI RECT NURS.
					HRS.)
	8. 00	9. 00	10.00	11. 00	13. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 246, 928	588, 601	223, 393	145, 506	67, 111 118. 00
NONREI MBURSABLE COST CENTERS	1 _	T _			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	629	
191. 00 19100 RESEARCH	0	1, 870		1, 077	0 191.00
194.00 07950 OTHER NONRELMBURSABLE COST CENTERS 194.01 07951 BSU PHARMACY	0	0	0	0	0 194. 00 0 194. 01
194. 02 07952 PAVILLION PHARMACY	0	0		0	4 194. 02
194. 03 07953 VENDI NG		0	0	0	0 194. 03
194. 04 07954 CARELI NE				0	
194. 05 07955 WELLNESS CENTER	7, 773	5, 073		0	0 194. 05
194. 06 07956 PHYSI CI AN PRACTI CE CLI NI CS	0	9, 209		0	0 194. 06
194. 07 07957 PERINATAL CLINIC	0	0	0	0	0 194. 07
194. 08 07958 RENTAL PROPERTY	0	25, 134	0	0	0 194. 08
194. 09 07959 ADVERTI SI NG	0	0	0	0	0 194. 09
194.10 07960 INTEGRA LTAC	0	0	11, 381	0	0 194. 10
194. 11 07961 IU HEALTH HOSPICE	0	3, 041	0	0	0 194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0 194. 12
194. 13 07963 PEDI ATRI C THERAPI ES	0	0	0	0	
194.14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	1 - 1 - 1 - 1 - 1
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS	0	0	0	0	
194. 16 07966 JAY COUNTY HOSPITAL	0	4, 968		770	1
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0		0	
194. 18 07968 CHV CARDI NAL HEALTH VENTURES	0	0	0	0	1
194.19 07969 HEALTH CARE CONNECTIONS 194.20 07970 MEALS ON WHEELS	0	0	0	0	0 194. 19
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0	
194. 22 07972 THERAPIES TO OTHER ENTITIES		0		0	
194. 23 07973 CANCER CENTER BOUTIQUE		852		43	
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0		0	
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	Ö		0	1
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	3, 451	O	644	0 194. 26
194.27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0 194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0 194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0 194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0	0	0	0 194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194. 31
194. 32 07982 RENAL DI ALYSI S	0	0	0	0	0 194. 32
194. 33 07983 LAB CORP	0]	0	0	0 194. 33
194. 34 07984 H. O. MATERI ALS MGMT	0			0	0 194. 34
194. 35 07985 LEASED SPACE				0	0 194. 35
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers					200. 00
202.00 Regative cost centers 202.00 Cost to be allocated (per Wkst. B,	1, 439, 477	7, 040, 511	4, 643, 130	2, 148, 408	
Part I)	1,437,477	7,040,511	4, 043, 130	2, 140, 400	7, 370, 137, 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 147267	10. 963130	19. 777020	14. 450948	110. 227796 203. 00
204.00 Cost to be allocated (per Wkst. B,	2, 696	l e		313, 543	
Part II)	, , , , ,			,	
205.00 Unit cost multiplier (Wkst. B, Part	0. 002149	0. 703727	2. 528956	2. 109001	5. 469374 205. 00
206.00 NAHE adjustment amount to be allocated					206. 00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,					207. 00
Parts III and IV)	1	I	1		ı l

	LLOCATION - STATISTICAL BASIS	DALL MEMORIAL	Provi der CO	CN: 15-0089 P	eri od:	Worksheet B-1	
				F	rom 01/01/2023	Date/Time Pre	
				'	0 12/31/2023	5/24/2024 9: 2	pareu: 1 am
					OTHER GENERAL	INTERNS &	
		05117041	BUA BUA OV		SERVI CE	RESI DENTS	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY (COSTED	MEDICAL RECORDS &	PATI ENT TRANSPORTATI ON	SERVICES-SALAR Y & FRINGES	
		SUPPLY	REQUIS.)	LI BRARY	TRANSPORTATION	(ASSI GNED	
		(COSTED	REGUI S.)	(GROSS	(GROSS	TIME)	
		REQUIS.)		CHARGES)	CHARGES)		
	T	14. 00	15. 00	16. 00	18. 00	21. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 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 ADMI TTI NG						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						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	37, 770, 355					14. 00
15. 00	01500 PHARMACY	104, 918	73, 418, 169				15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	2, 464, 468, 227			16. 00
18. 00	01080 PATIENT TRANSPORTATION	0	0	0	2, 464, 468, 227		18. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	10, 553	0	0	0	5, 042	
22. 00 23. 00	O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD O2300 PARAMED ED PRGM	19, 553	0		0		22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0		9		23.00
30.00		1, 476, 061	331, 406	272, 216, 133	272, 216, 133	3, 064	30.00
	03100 INTENSIVE CARE UNIT	486, 261	220, 870	60, 827, 055	60, 827, 055	600	
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
35. 00 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	99, 235	16, 991	14, 653, 983	14, 653, 983	36 0	35. 00 40. 00
41. 00	04100 SUBPROVIDER - I RF	31, 266	2, 817	13, 004, 438	13, 004, 438	0	1
	04300 NURSERY	0	2, 317	3, 516, 138		0	1
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	6, 314, 507	111, 435			154 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	72, 037 184, 991	85, 806 46, 137			0	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 018, 127	235, 415			174	1
57. 00	05700 CT SCAN	68, 940	27, 870			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 647, 677	64, 996	128, 463, 185 122, 622, 894		0	
60. 00	06001 BLOOD LABORATORY		0	122, 022, 094		0	ı
	06300 BLOOD STORING, PROCESSING, & TRANS.	O	0	7, 647, 350		0	63.00
65.00	06500 RESPI RATORY THERAPY	509, 016	0	32, 576, 084	32, 576, 084	210	65. 00
65. 01	06501 SLEEP LAB	45, 043	75			0	
66.00	06600 PHYSI CAL THERAPY	23, 690	0	24, 990, 967		0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	212	0	7, 595, 158 4, 460, 826		0	67. 00 68. 00
68. 01	06801 AUDI OLOGY	0	0	0 4, 400, 020	0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	15, 055	3, 779	49, 283, 823	49, 283, 823	224	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 546, 638	0	99, 845, 529		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	11, 115, 864	0	155, 942, 276		0	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	987	52, 199, 006 10, 474, 373			0	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	7, 331	996	4, 331, 344		0	74. 00
	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 488	3	7, 221, 569		0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	217, 171	0	24, 186, 899	24, 186, 899	4	76. 98
77. 00 78. 00	O7700 ALLOGENEIC HSCT ACQUISITION O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	
78.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	O		9	0	78.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	1, 463	0	741, 027		0	
90. 02	09002 PAIN CLINIC	19, 457	726			99	1
90. 03 91. 00	O9003 ONCOLOGY CLI NI C O9100 EMERGENCY	105, 770 614, 545	85, 556 451, 385			75 345	90. 03 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	314, 343	451, 365	273, 170, 200	273, 170, 200	545	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	12, 630	8, 170	8, 693, 279	8, 693, 279	0	1
05.05	OTHER REIMBURSABLE COST CENTERS			-			05.05
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM	0	0	0			95. 00 102. 00
	TIOZOO OTTOTO TREATMENT TROOKAW	1 9	O ₁	<u> </u>	١	0	1.02.00

Health Financial Systems	BALL MEMORIAL	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre	nared:
				10 12/31/2023	5/24/2024 9: 2	
				OTHER GENERAL	INTERNS &	
				SERVI CE	RESI DENTS	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		SERVI CES-SALAR	
	SERVICES &	(COSTED	RECORDS &	TRANSPORTATI ON		
	SUPPLY	REQUIS.)	LI BRARY	(CDOCC	(ASSI GNED	
	(COSTED REQUIS.)		(GROSS CHARGES)	(GROSS CHARGES)	TI ME)	
	14. 00	15. 00	16.00	18. 00	21. 00	
SPECIAL PURPOSE COST CENTERS	1			10.00		
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	37, 759, 984	64, 367, 812	2, 464, 468, 22	7 2, 464, 468, 227	4, 985	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5	0		0		190. 00
191. 00 19100 RESEARCH	55	0	(0		191. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
194. 01 07951 BSU_PHARMACY 194. 02 07952 PAVILLION_PHARMACY	2 001	9, 050, 357)			194. 01 194. 02
194. 03 07953 VENDI NG	2, 881	9, 050, 357	}			194. 02
194. 04 07954 CARELI NE		0				194. 03
194. 05 07955 WELLNESS CENTER		0				194. 05
194. 06 07956 PHYSI CI AN PRACTI CE CLINI CS	l ol	0		ol ol		194. 06
194. 07 07957 PERINATAL CLINIC	o	0		o		194. 07
194.08 07958 RENTAL PROPERTY	475	0		o	0	194. 08
194. 09 07959 ADVERTI SI NG	0	0	(0	0	194. 09
194. 10 07960 I NTEGRA LTAC	0	0	(0		194. 10
194. 11 07961 I U HEALTH HOSPI CE	0	0	(0		194. 11
194. 12 07962 POB MEDICAL PAVILLION CONDOS	0	0	9	0		194. 12
194. 13 07963 PEDI ATRI C THERAPI ES	6, 955	0		0		194. 13
194. 14 07964 NEW CASTLE ONCOLOGY	0	0				194. 14 194. 15
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS 194. 16 07966 JAY COUNTY HOSPI TAL	0	0)			194. 15
194. 17 07967 CARDI NAL HEALTH CHOI CE		0				194. 17
194. 18 07968 CHV CARDI NAL HEALTH VENTURES		0				194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	l ol	0		ol ol		194. 19
194.20 07970 MEALS ON WHEELS	o	0		o	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	o	0		o	0	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	0	0		0	0	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	0	0	(0		194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0	(0		194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0		0		194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 194. 27 07977 MIDWEST HEALTH STRATEGIES	0	0				194. 26
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0)			194. 27 194. 28
194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI		0				194. 20
194. 30 07980 CARDI NAL HEALTH ALLI ANCE		0				194. 30
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS	l ol	0		ol ol		194. 31
194. 32 07982 RENAL DIALYSIS	o	0		o		194. 32
194. 33 07983 LAB CORP	o	0		o	0	194. 33
194.34 07984 H.O. MATERIALS MGMT	0	0	(0		194. 34
194. 35 07985 LEASED SPACE	0	0	(0	0	194. 35
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	44 (00 474	40.004.440		0.700.540	5 040 000	201. 00
202.00 Cost to be allocated (per Wkst. B,	14, 629, 471	10, 904, 469		2, 799, 562	5, 348, 322	202. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 387327	0 140525	0.00000	0 001134	1 040 754044	202 00
204.00 Cost to be allocated (per Wkst. B,		0. 148525 283, 744	•	0. 001136 42, 919		1
Part II)	772, 993	203, 144		42, 919	10, 537	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 020466	0. 003865	0. 000000	0. 000017	2. 089845	205, 00
	122.30					
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	ı İ		I	1		I

Heal th 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 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am INTERNS & **RESI DENTS** PARAMED ED Cost Center Description SERVI CES-OTHER PRGM COSTS PRGM (ASSI GNED (100% TIME) **PHARMACY** DRUGS) 22.00 23.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 5.01 01160 COMMUNI CATI ONS 5.01 00550 DATA PROCESSING 5 02 5 02 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 00600 MAINTENANCE & REPAIRS 6 00 6 00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15 00 01500 PHARMACY 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 18.00 01080 PATIENT TRANSPORTATION 18.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 5.042 22.00 02300 PARAMED ED PRGM 100 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 3.064 31.00 03100 INTENSIVE CARE UNIT 600 0 31.00 03200 CORONARY CARE UNIT 32.00 0 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 36 0 35.00 04000 SUBPROVIDER - IPF 40.00 0 0 40.00 04100 SUBPROVIDER - IRF 0 41.00 0 41.00 04300 NURSERY 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 154 0 50.00 05100 RECOVERY ROOM 0 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 174 54.00 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 0 63.00 06500 RESPIRATORY THERAPY 210 0 65 00 65 00 65.01 06501 SLEEP LAB 0 0 65.01 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68 00 68.01 06801 AUDI OLOGY 0 0 68.01 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 000000040 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72 00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 73 01 0 73 01 07400 RENAL DIALYSIS 74 00 0 74 00 76.00 03160 CARDI OPULMONARY 0 76.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76. 98 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 SUBSTANCE ABUSE CLINIC 90.01 0 0 90.01 09002 PAIN CLINIC 99 90.02 0 90.02 09003 ONCOLOGY CLINIC 90.03 75 0 90.03 09100 EMERGENCY 91.00 345 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95 00 95 00 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 Health Financial Systems

BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CON: 15-0089

Period: Worksheet R-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0089 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am INTERNS & **RESI DENTS** PARAMED ED Cost Center Description SERVI CES-OTHER PRGM COSTS PRGM (ASSI GNED (100% TIME) **PHARMACY** DRUGS) 22.00 23.00 SPECIAL PURPOSE COST CENTERS 113 00 113.00 11300 I NTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 985 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 0 57 191. 00 19100 RESEARCH 0 191.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 00 194. 01 07951 BSU PHARMACY 0 194.01 194. 02 07952 PAVILLION PHARMACY 194 02 0 194. 03 07953 VENDI NG 0 194.03 194. 04 07954 CARELI NE 0 194.04 194. 05 07955 WELLNESS CENTER 0 194. 05 194. 06 07956 PHYSICIAN PRACTICE CLINICS 194. 06 0 194. 07 07957 PERINATAL CLINIC 0 194. 07 194. 08 07958 RENTAL PROPERTY 194. 08 194. 09 07959 ADVERTI SI NG 0 194. 09 194. 10 07960 I NTEGRA LTAC 0 194 10 194. 11 07961 I U HEALTH HOSPI CE 0 194. 11 194. 12 07962 POB MEDICAL PAVILLION CONDOS 0 194. 12 0 194. 13 07963 PEDIATRIC THERAPIES 194. 13 194.14 07964 NEW CASTLE ONCOLOGY 194. 14 194. 15 07965 MARKETING/PUBLIC RELATIONS 0 194. 15 194. 16 07966 JAY COUNTY HOSPITAL 0 194. 16 194. 17 07967 CARDI NAL HEALTH CHOICE 0 194. 17 194. 18 07968 CHV CARDI NAL HEALTH VENTURES 0 194. 18 194. 19 07969 HEALTH CARE CONNECTIONS 194. 19 0 194. 20 07970 MEALS ON WHEELS 194. 20 194. 21 07971 ST MARY'S SCHOOL 0 194. 21 194. 22 07972 THERAPIES TO OTHER ENTITIES 194. 22 0 194. 23 194. 23 07973 CANCER CENTER BOUTIQUE 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 0 194 24 0 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 194. 25 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 0 194. 26 194. 27 07977 MI DWEST HEALTH STRATEGIES 194. 27 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 194. 28 194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI 0 194. 29 194. 30 07980 CARDI NAL HEALTH ALLI ANCE 194. 30 194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS 0 194. 31 194. 32 07982 RENAL DIALYSIS 0 194. 32 194. 33 07983 LAB CORP 0 194. 33 194. 34 07984 H. O. MATERIALS MGMT 0 194. 34 0 194. 35 07985 LEASED SPACE 194 35 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 7. 369. 310 333.894 202.00 Part I) 1, 461. 584689 203 00 Unit cost multiplier (Wkst. B, Part I) 3, 338. 940000 203 00 204. 00 204.00 Cost to be allocated (per Wkst. B, 1, 416, 243 6,773 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 280. 889131 67.730000 205.00 II)206.00 NAHE adjustment amount to be allocated 206. 00 Ω

0.000000

207.00

207.00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

In Lieu of Form CMS-2552-10
Worksheet C
01/2023 Part I
01/2023 Date/Time Prepared:
5/24/2024 9:21 am
tal PPS Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0089 Peri od: From 01/01/2023 To 12/31/2023 Title XVIII Hospi tal

				7,,,,,,	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
		Part I, col.	Auj .		DI Sai i Owance		
		26)	2.00	2.00	4.00	Г 00	
	LAIDATI FAIT DOUTLAIF OFFILIAF AGOT OFFITEDS	1.00	2. 00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	07.007.010		07.007.040	اء	07 007 040	
30. 00	03000 ADULTS & PEDIATRICS	87, 887, 812		87, 887, 812	0	87, 887, 812	
31. 00	03100 I NTENSI VE CARE UNI T	18, 573, 713		18, 573, 713	0	18, 573, 713	
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 809, 690		4, 809, 690	0	4, 809, 690	
40.00	04000 SUBPROVI DER - I PF	0		0	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	4, 850, 683		4, 850, 683	0	4, 850, 683	41.00
43.00	04300 NURSERY	1, 319, 701		1, 319, 701	0	1, 319, 701	43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	25, 868, 968		25, 868, 968	0	25, 868, 968	50. 00
51.00	05100 RECOVERY ROOM	5, 062, 850		5, 062, 850	ol	5, 062, 850	
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 823, 438		7, 823, 438	o	7, 823, 438	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	27, 920, 913		27, 920, 913	ol	27, 920, 913	
57. 00	05700 CT SCAN	3, 559, 524		3, 559, 524	o	3, 559, 524	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0, 337, 324		0, 557, 524	o	0, 557, 524	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	8, 330, 114		8, 330, 114	o	8, 330, 114	
	06000 LABORATORY				-		
60.00		22, 826, 680		22, 826, 680	0	22, 826, 680	
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 777, 703	_	1, 777, 703	0	1, 777, 703	
65. 00	06500 RESPI RATORY THERAPY	7, 618, 150		,	0	7, 618, 150	
65. 01	06501 SLEEP LAB	1, 060, 400			0	1, 060, 400	
66.00	06600 PHYSI CAL THERAPY	10, 257, 666	0	10, 257, 666	0	10, 257, 666	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 836, 230	0	1, 836, 230	0	1, 836, 230	67. 00
68.00	06800 SPEECH PATHOLOGY	1, 023, 178	0	1, 023, 178	0	1, 023, 178	68. 00
68. 01	06801 AUDI OLOGY	0	0	0	o	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	5, 299, 977		5, 299, 977	ol	5, 299, 977	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 252, 221		22, 252, 221	ol	22, 252, 221	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	19, 864, 813		19, 864, 813	ol	19, 864, 813	
73. 00	07300 DRUGS CHARGED TO PATIENTS	74, 138, 068		74, 138, 068	ol	74, 138, 068	
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	28, 084, 505		28, 084, 505	ol	28, 084, 505	
74. 00	07400 RENAL DIALYSIS	2, 117, 044		2, 117, 044	o	2, 117, 044	
76. 00	03160 CARDI OPULMONARY	2,117,044		2, 117, 044	ol	2, 117, 044	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1 ((0 121		·	o		
		1, 669, 121		1, 669, 121	_	1, 669, 121	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 634, 096		2, 634, 096	0	2, 634, 096	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			1			
90. 00	09000 CLI NI C	0		0	0	0	
90. 01	09001 SUBSTANCE ABUSE CLINIC	1, 212, 376		1, 212, 376	0	1, 212, 376	
90. 02	09002 PAIN CLINIC	2, 327, 817		2, 327, 817	0	2, 327, 817	
90. 03	09003 ONCOLOGY CLINIC	6, 479, 513		6, 479, 513	0	6, 479, 513	90. 03
91.00	09100 EMERGENCY	27, 659, 326		27, 659, 326	498, 132	28, 157, 458	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 976, 588		12, 976, 588		12, 976, 588	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	2, 124, 759		2, 124, 759	o	2, 124, 759	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
95 00	09500 AMBULANCE SERVICES	54, 611		54, 611	ol	54, 611	95. 00
	10200 OPIOID TREATMENT PROGRAM	01,011		0 0	ĭ		102. 00
102.00	SPECIAL PURPOSE COST CENTERS			<u> </u>			1.02.00
113 00	11300 I NTEREST EXPENSE						113. 00
200.00		451, 302, 248	О	451, 302, 248	498, 132	451, 800, 380	
200.00	, ,				470, 132	12, 976, 588	
		12, 976, 588		12, 976, 588	400 122		
202.00	Total (see instructions)	438, 325, 660	0	438, 325, 660	498, 132	438, 823, 792	1202.00

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 9:21 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 206, 825, 298 206, 825, 298 30.00 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 60, 827, 055 60, 827, 055 31.00 03200 CORONARY CARE UNIT 32.00 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 14, 653, 983 14, 653, 983 35.00 04000 SUBPROVIDER - IPF 40 00 C 40.00 41.00 04100 SUBPROVIDER - IRF 13, 004, 438 13, 004, 438 41.00 43.00 04300 NURSERY 3, 516, 138 3, 516, 138 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 104, 528, 028 135, 675, 915 240, 203, 943 0.107696 0.000000 50.00 51.00 05100 RECOVERY ROOM 8, 951, 727 24, 124, 514 33, 076, 241 0.153066 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 755, 891 3, 774, 099 29, 529, 990 0.264932 0.000000 52.00 222, 909, 757 05400 RADI OLOGY-DI AGNOSTI C 47, 401, 917 270, 311, 674 54.00 0.103292 0.000000 54.00 57.00 05700 CT SCAN 21, 341, 038 36, 051, 243 57, 392, 281 0.062021 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 55, 498, 409 72, 964, 776 128, 463, 185 0.064844 0.000000 59.00 06000 LABORATORY 60 00 56, 039, 688 66, 583, 206 122, 622, 894 0.186153 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 5, 778, 413 63.00 1, 868, 937 7, 647, 350 0.232460 0.000000 63.00 06500 RESPIRATORY THERAPY 32, 576, 084 65.00 27.837.473 4, 738, 611 0.233857 0.000000 65.00 8, 995, 672 65.01 06501 SLEEP LAB 13, 164 9, 008, 836 0.117707 0.000000 65.01 66.00 66.00 06600 PHYSI CAL THERAPY 10, 016, 966 14, 974, 001 24, 990, 967 0.410455 0.000000 67.00 06700 OCCUPATIONAL THERAPY 7, 209, 802 385, 356 7, 595, 158 0. 241763 0.000000 67.00 06800 SPEECH PATHOLOGY 4, 035, 941 424, 885 4, 460, 826 0 229370 0 000000 68 00 68 00 68.01 06801 AUDI OLOGY 0.000000 0.000000 68.01 06900 ELECTROCARDI OLOGY 19, 957, 594 29, 326, 229 49, 283, 823 0. 107540 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 44, 045, 696 55, 799, 833 99, 845, 529 0. 222866 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 83, 878, 997 155, 942, 276 72.00 72, 063, 279 0.127386 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 108, 865, 795 300, 152, 163 409, 017, 958 0.181259 0.000000 73.00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 21, 891, 431 21, 891, 431 1.282899 0.000000 73.01 74 00 07400 RENAL DIALYSIS 3, 824, 863 506, 481 4, 331, 344 0 488773 0 000000 74 00 03160 CARDI OPULMONARY 76.00 0.000000 0.000000 76.00 07697 CARDIAC REHABILITATION 1, 393, 689 5, 827, 880 7, 221, 569 0.231130 0.000000 76. 97 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 86, 327 24, 100, 572 24, 186, 899 0.108906 0.000000 76.98 07700 ALLOGENEIC HSCT ACQUISITION 77 00 C 0.000000 0.000000 77 00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 \overline{C} 0.000000 0.000000 90.00 09001 SUBSTANCE ABUSE CLINIC 90 01 740, 894 741, 027 133 1.636075 0.000000 90 01 90.02 09002 PAIN CLINIC 6, 202 3, 400, 233 3, 406, 435 0.683359 0.000000 90.02 90.03 09003 ONCOLOGY CLINIC 1, 471, 178 50, 540, 037 52, 011, 215 0.124579 0.000000 90.03 78, 369, 921 217, 428, 345 0.093507 91.00 09100 EMERGENCY 295, 798, 266 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 198447 1, 473, 900 65, 390, 835 92.00 63, 916, 935 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 69,677 8, 623, 602 8, 693, 279 0.244414 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS

0

0

1, 016, 679, 341 1, 447, 788, 886 2, 464, 468, 227

1, 016, 679, 341 1, 447, 788, 886 2, 464, 468, 227

95.00

102.00

113. 00

200. 00

201. 00

202.00

0.000000

0.000000

0

0

09500 AMBULANCE SERVICES

102.00 10200 OPI OID TREATMENT PROGRAM

113. 00 11300 | INTEREST EXPENSE

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

95.00

200.00

201.00

202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0089

Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am

			T: +1 - W// 1 1	11	5/24/2024 9:21 am
	Cook Cookers December 1	DDC Lameticat	Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Rati o 11.00			
	NPATIENT ROUTINE SERVICE COST CENTERS	11.00			
	03000 ADULTS & PEDIATRICS				30.00
	D3100 INTENSIVE CARE UNIT				31.00
	03200 CORONARY CARE UNIT				32.00
	D2060 NEONATAL INTENSIVE CARE UNIT				35. 00
	04000 SUBPROVI DER – I PF				40.00
	04100 SUBPROVI DER – I RF				41.00
	04300 NURSERY				43.00
_	ANCI LLARY SERVI CE COST CENTERS				10.00
	D5000 OPERATI NG ROOM	0. 107696			50.00
	D5100 RECOVERY ROOM	0. 153066			51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0. 264932			52.00
	D5400 RADI OLOGY-DI AGNOSTI C	0. 103292			54.00
	05700 CT SCAN	0. 062021			57. 00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 064844			59. 00
	06000 LABORATORY	0. 186153			60.00
	06001 BLOOD LABORATORY	0. 000000			60. 01
	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 232460			63. 00
	06500 RESPIRATORY THERAPY	0. 233857			65. 00
	06501 SLEEP LAB	0. 117707			65. 01
	D6600 PHYSI CAL THERAPY	0. 410455			66. 00
	06700 OCCUPATIONAL THERAPY	0. 241763			67. 00
	06800 SPEECH PATHOLOGY	0. 229370			68. 00
	06801 AUDI OLOGY	0. 000000			68. 01
69.00	06900 ELECTROCARDI OLOGY	0. 107540			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 222866			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 127386			72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0. 181259			73. 00
	07301 HOSPITAL BASED RETAIL PHARMACIES	1. 282899			73. 01
	07400 RENAL DIALYSIS	0. 488773			74. 00
	D3160 CARDI OPULMONARY	0. 000000			76. 00
	07697 CARDIAC REHABILITATION	0. 231130			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0. 108906			76. 98
	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	0.000000			90.00
	09001 SUBSTANCE ABUSE CLINIC	1. 636075			90. 01
	D9002 PAIN CLINIC	0. 683359			90. 02
	D9003 ONCOLOGY CLINIC	0. 124579			90. 03
	09100 EMERGENCY	0. 095191			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 198447			92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0. 244414			92. 01
	OTHER REIMBURSABLE COST CENTERS	0.000000			05.00
	09500 AMBULANCE SERVI CES	0. 000000			95. 00
	10200 OPI OI D TREATMENT PROGRAM				102. 00
	SPECIAL PURPOSE COST CENTERS				112.00
	11300 INTEREST EXPENSE				113. 00
200. 00 201. 00	Subtotal (see instructions) Less Observation Beds				200. 00 201. 00
201.00	Total (see instructions)	1			201.00
202.00	Total (See Histructions)				1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/24/2024 9:21 am Provider CCN: 15-0089

					0 12/31/2023	5/24/2024 9: 2	1 am
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 5511tol. 25551 Pt. 511	(from Wkst. B,	Adj .	1014. 00010	Di sal I owance		
		Part I, col.	riag .		Di Sai i olianee		
		26)					
		1.00	2.00	3.00	4.00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS	87, 887, 812		87, 887, 812	ام	87, 887, 812	30. 00
	03100 INTENSIVE CARE UNIT				I		
31.00		18, 573, 713		18, 573, 713		18, 573, 713	
32. 00	03200 CORONARY CARE UNIT	0			0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 809, 690		4, 809, 690	I I	4, 809, 690	
40.00	04000 SUBPROVI DER - I PF	0		(0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	4, 850, 683		4, 850, 683	I I	4, 850, 683	
43.00	04300 NURSERY	1, 319, 701		1, 319, 70	0	1, 319, 701	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	25, 868, 968		25, 868, 968		25, 868, 968	50. 00
51.00	05100 RECOVERY ROOM	5, 062, 850		5, 062, 850	0	5, 062, 850	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 823, 438		7, 823, 438	0	7, 823, 438	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 920, 913		27, 920, 913	o o	27, 920, 913	54.00
57.00	05700 CT SCAN	3, 559, 524		3, 559, 524	ıl ol	3, 559, 524	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		' (58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	8, 330, 114		8, 330, 114	0	8, 330, 114	59. 00
60.00	06000 LABORATORY	22, 826, 680		22, 826, 680		22, 826, 680	
60. 01	06001 BLOOD LABORATORY	0 22,020,000		22, 020, 000		0.020	60. 01
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 777, 703		1, 777, 703	′I "I	1, 777, 703	
65. 00	06500 RESPIRATORY THERAPY	7, 618, 150	0			7, 618, 150	
65. 01	06501 SLEEP LAB	1, 060, 400	0			1, 060, 400	65. 01
	06600 PHYSI CAL THERAPY		0				
66.00		10, 257, 666	_	, ,		10, 257, 666	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 836, 230	0		I I	1, 836, 230	
68. 00	06800 SPEECH PATHOLOGY	1, 023, 178	0		I I	1, 023, 178	
68. 01	06801 AUDI OLOGY	5 000 077	0		0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	5, 299, 977		5, 299, 97		5, 299, 977	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 252, 221		22, 252, 22		22, 252, 221	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	19, 864, 813		19, 864, 813	I	19, 864, 813	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	74, 138, 068		74, 138, 068		74, 138, 068	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	28, 084, 505		28, 084, 505		28, 084, 505	73. 01
74.00	07400 RENAL DIALYSIS	2, 117, 044		2, 117, 044	0	2, 117, 044	74.00
76.00	03160 CARDI OPULMONARY	0		(0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	1, 669, 121		1, 669, 12	0	1, 669, 121	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 634, 096		2, 634, 096	0	2, 634, 096	76. 98
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		(0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		(ol	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		(0	0	90. 00
90. 01	09001 SUBSTANCE ABUSE CLINIC	1, 212, 376		1, 212, 376	ol ol	1, 212, 376	90. 01
90. 02	09002 PAIN CLINIC	2, 327, 817		2, 327, 817		2, 327, 817	
90. 03	09003 ONCOLOGY CLINIC	6, 479, 513		6, 479, 513		6, 479, 513	
91. 00	09100 EMERGENCY	27, 659, 326		27, 659, 326		28, 157, 458	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 976, 588		12, 976, 588		12, 976, 588	92. 00
92. 01	09201 OBSERVATION BEDS (NON-DISTINCT PART)	2, 124, 759		2, 124, 759		2, 124, 759	
72.01	OTHER REIMBURSABLE COST CENTERS	2, 124, 739		2, 124, 75	ή	2, 124, 737	92.01
05 00	09500 AMBULANCE SERVICES	E4 (11		E4 (1)	ا	E4 (11	05 00
95.00		54, 611		54, 61		54, 611	
102.00	10200 OPI OI D TREATMENT PROGRAM	0			<u> </u>	0	102. 00
110 01	SPECIAL PURPOSE COST CENTERS						110 00
	11300 INTEREST EXPENSE	454 000 010	_	454 000 044	400 100	454 000 000	113. 00
200.00		451, 302, 248	0			451, 800, 380	
201.00		12, 976, 588		12, 976, 588		12, 976, 588	
202.00	Total (see instructions)	438, 325, 660	0	438, 325, 660	498, 132	438, 823, 792	202.00

Provider CCN: 15-0089

						10 12/31/2023	5/24/2024 9: 2	
				Ti tl	e XIX	Hospi tal	PPS	
				Charges				
		Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
		·			+ col . 7)	Ratio	Inpati ent	
					<u> </u>		Rati o	
			6.00	7. 00	8. 00	9. 00	10.00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDI ATRI CS	206, 825, 298		206, 825, 29	8		30. 00
31.00		INTENSIVE CARE UNIT	60, 827, 055		60, 827, 05	5		31.00
32.00	03200	CORONARY CARE UNIT	0			0		32.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	14, 653, 983		14, 653, 98	3		35. 00
40.00		SUBPROVIDER - IPF	0			0		40. 00
41.00		SUBPROVI DER - I RF	13, 004, 438		13, 004, 43			41. 00
43.00		NURSERY	3, 516, 138		3, 516, 13	8		43.00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM	104, 528, 028	135, 675, 915			l e	50. 00
51. 00		RECOVERY ROOM	8, 951, 727	24, 124, 514			0.000000	51.00
52.00		DELIVERY ROOM & LABOR ROOM	25, 755, 891	3, 774, 099			0.000000	
54.00		RADI OLOGY-DI AGNOSTI C	47, 401, 917	222, 909, 757			0.000000	
57.00		CT SCAN	21, 341, 038	36, 051, 243	57, 392, 28		0.000000	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0. 000000	0.000000	
59. 00		CARDI AC CATHETERI ZATI ON	55, 498, 409	72, 964, 776			0.000000	
60.00		LABORATORY	56, 039, 688	66, 583, 206	122, 622, 89		0.000000	
60. 01	1	BLOOD LABORATORY	0	0	1	0. 000000	0.000000	60. 01
63.00		BLOOD STORING, PROCESSING, & TRANS.	5, 778, 413	1, 868, 937			0.000000	63. 00
65. 00		RESPI RATORY THERAPY	27, 837, 473	4, 738, 611			0.000000	65. 00
65. 01		SLEEP LAB	13, 164	8, 995, 672			0.000000	65. 01
66. 00		PHYSI CAL THERAPY	10, 016, 966	14, 974, 001			0.000000	66. 00
67. 00		OCCUPATI ONAL THERAPY	7, 209, 802	385, 356			0.000000	67. 00
68. 00		SPEECH PATHOLOGY	4, 035, 941	424, 885	4, 460, 82		0.000000	68. 00
68. 01		AUDI OLOGY	0	0	1	0. 000000	0.000000	68. 01
69. 00		ELECTROCARDI OLOGY	19, 957, 594	29, 326, 229			0. 000000	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	44, 045, 696	55, 799, 833			0. 000000	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENT	83, 878, 997	72, 063, 279			0.000000	
73. 00		DRUGS CHARGED TO PATIENTS	108, 865, 795	300, 152, 163			0.000000	73. 00
73. 01		HOSPITAL BASED RETAIL PHARMACIES	0	21, 891, 431			0. 000000	
74. 00		RENAL DIALYSIS	3, 824, 863	506, 481	1		0. 000000	74. 00
76. 00		CARDI OPULMONARY	0	0	1	0. 000000	0. 000000	
76. 97		CARDIAC REHABILITATION	1, 393, 689	5, 827, 880			0. 000000	76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	86, 327	24, 100, 572			0. 000000	76. 98
77. 00		ALLOGENEIC HSCT ACQUISITION	0	0	l .	0. 000000	0. 000000	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0. 000000	78. 00
		TIENT SERVICE COST CENTERS	1 _1		1			
90.00		CLINIC	0	0	l .	0.000000	0.000000	
90. 01		SUBSTANCE ABUSE CLINIC	133	740, 894			0.000000	
90. 02		PAIN CLINIC	6, 202	3, 400, 233			0.000000	
90. 03		ONCOLOGY CLINIC	1, 471, 178	50, 540, 037			0.000000	90. 03
91.00		EMERGENCY	78, 369, 921	217, 428, 345			0.000000	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	1, 473, 900	63, 916, 935			0.000000	
92. 01		OBSERVATION BEDS (DISTINCT PART)	69, 677	8, 623, 602	8, 693, 27	9 0. 244414	0.000000	92. 01
		REI MBURSABLE COST CENTERS	1					
95. 00		AMBULANCE SERVICES	0	0		0.000000	0.000000	
102.00	10200	OPI OI D TREATMENT PROGRAM	0	0	1	0		102. 00
110 00		AL PURPOSE COST CENTERS						112 00
		INTEREST EXPENSE	1 01/ /70 044	1 447 700 004	2 4/4 4/0 00	7		113. 00
200.00	1	Subtotal (see instructions)	1,016,679,341	1, 447, 788, 886	2, 404, 468, 22	/		200. 00
201.00	1	Less Observation Beds	1 014 470 241	1 447 700 007	2 464 460 22	7		201. 00
202.00	'	Total (see instructions)	1,016,679,341	1, 447, 788, 886	₁ ∠, 404, 468, 22	1		202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0089

Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am

INPATIENT ROUTH RESERVICE COST CENTERS				T		5/24/2024 9: 21 am
IMPATIENT ROUTINE SERVICE COST CENTERS 11.00				Title XIX	Hospi tal	PPS
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30000 ABULTIS & PEDIATRIC S 30.00 30000 ABULTIS & PEDIATRIC S 31.00		Cost Center Description				
IMPATIENT ROUTINE SERVICE COST CENTERS 30 00 00 00 00 00 00 00 00 00 00 00 00						
30.00 3000 ADULTS & PEDIATRICS 31.00 31.			11.00			
31.00 03100 NTEINS IVE CARE UNIT 32.00 03200 CORROMARY CARE UNIT 35.00 04.00 04.00 04.000						
32 0 0 3200 COROMARY CARE UNIT						
35. 00 20500 NEONATAL INTENSIVE CARE UNIT						
40, 00 4000 SUBPROVI DER - I PF						32.00
41.00 40100 SUBPROVIDER - IRF 41.00 43.00 43.00 43.00 43.00 04200 NURSERY						
43. 00 A300 NURSERY						40. 00
MACILLARY SERVICE COST CENTERS 50.00	41.00 041	100 SUBPROVI DER - I RF				41.00
50.00	43.00 043	NURSERY				43. 00
51.00 05100 RECOVERY ROOM 0.0 153066 51.00 52.00 52.00 05400 RADIO LOGY-DIAGNOSTIC 0.0 103292 52.00 53.00 05400 RADIO LOGY-DIAGNOSTIC 0.0 103292 54.00 57.00	ANC	CILLARY SERVICE COST CENTERS				
52.00 0520	50.00 050	OOO OPERATING ROOM	0. 107696			50.00
54. 00 05400 RADI OLOGY-DI ASNOSTIC 0. 103292 54. 00 57. 00 05700 CT SCAN 0. 062021 57. 00 05700 CARDI AC CATHETERIZATI ON 0. 064844 59. 00 06900 CARDI AC CATHETERIZATI ON 0. 186153 60. 00 06000 LABORATORY 0. 186153 60. 00 06000 LABORATORY 0. 0000000 060000 06000 060000 060000 060000 060000 060000 0600000 060000 060000 0600000 0600000 06000000 060000000	51.00 051	100 RECOVERY ROOM	0. 153066			51.00
57. 00 05700 CT SCAN 57. 00 58. 00 05800 MagNETIC RESONANCE IMAGING (INRI.) 0. 0000000 59. 00 05900 CARDIAC CATHETERIZATION 0. 064844 59. 00 00. 000000 LABORATORY 0. 186153 60. 00 00. 00000 LABORATORY 0. 186153 60. 00 00. 00000 0. 00. 01 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 0001 0. 00000 0. 00. 00000 0. 00. 00000 0. 00. 0	52.00 052	200 DELIVERY ROOM & LABOR ROOM	0. 264932			52. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0.000000 58. 00 05900 CARDIAC CATHETERIZATION 0.064844 59. 00 05900 CARDIAC CATHETERIZATION 0.064814 60. 00 06. 00 06. 00 01. 0500 LABORATORY 0.000000 0.00000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		400 RADI OLOGY-DI AGNOSTI C	0. 103292			54. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0.000000 58. 00 05900 CARDIAC CATHETERIZATION 0.064844 59. 00 05900 CARDIAC CATHETERIZATION 0.064814 60. 00 06. 00 06. 00 01. 0500 LABORATORY 0.000000 0.00000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	57.00 057	700 CT SCAN	0. 062021			57. 00
59, 00 05900 CARDI AC CATHETER ZATION 0.064814 60.00 06.00 06.000 LABORATORY 0.186153 60.00 06.000 06.000 LABORATORY 0.000000 60.01 06.001 06.001 06.001 06.001 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.00000 06.00000 06.00000 06.00000 06.00000 06.000000 06.000000 06.0000000 06.00000000 06.0000000000			0. 000000			58. 00
60. 00 0.0000 LABORATORY 0. 186153 0. 000000 0. 00001 0. 00001 0. 00001 0. 00001 0. 00001 0. 00001 0. 00001 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000			1 1			59.00
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65. 00 06500 RSPI RATORY THERAPY 0. 233857 65. 00 06501 SLEEP LAB 0. 117707 65. 01 06501 SLEEP LAB 0. 117707 65. 00 06600 PHYSI CAL THERAPY 0. 4170455 66. 00 06600 PHYSI CAL THERAPY 0. 241763 67. 00 06600 SPECER PATHOLOGY 0. 224763 68. 00 06600 SPECER PATHOLOGY 0. 000000 08. 01 06801 AUDI OLOGY 0. 000000 08. 01 06800 SPECER PATHOLOGY 0. 000000 08. 01 06900 ELECTROCARDI OLOGY 0. 000000 07. 00 07.	1	i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	1 1			
65. 01 06501 SLEEP LAB 0. 117707 0. 66. 00 06600 PHYSI CAL THERAPY 0. 410455 66. 00 06600 PHYSI CAL THERAPY 0. 410455 67. 00 06700 OCCUPATI ONAL THERAPY 0. 241763 67. 00 06800 SPECH PATHOLOGY 0. 229370 68. 00 06800 SPECH PATHOLOGY 0. 000000 68. 01 06801 AUDI OLOGY 0. 000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.00000 0.00000 0.0000000 0.00000000						
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68. 00 06800 SPEECH PATHOLOGY 0. 229370 68. 00 06800 AUDI OLOGY 0. 000000 68. 01 06800 AUDI OLOGY 0. 0000000 68. 01 06900 ELECTROCARDI OLOGY 0. 107540 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 222866 71. 00 72.00 IMPL. DEV. CHARGED TO PATI ENTS 0. 127386 72. 00 73. 00 DRUGS CHARGED TO PATI ENTS 0. 181259 73. 00 73. 01 07301 MOSPI TAL BASED RETAIL PHARMACI ES 1. 282899 73. 01 07301 MOSPI TAL BASED RETAIL PHARMACI ES 1. 282899 73. 01 07301 MOSPI TAL BASED RETAIL PHARMACI ES 1. 282899 73. 01 07301 MOSPI TAL BASED RETAIL PHARMACI ES 1. 282899 73. 01 07301 MOSPI TAL BASED RETAIL PHARMACI ES 1. 282899 73. 01 07301 MOSPI TAL BASED RETAIL PHARMACI ES 0. 488773 74. 00 76. 97 07697 CARDI AC REHABI LITATI ON 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000						
68. 01 06801 AUDI OLOGY 0.000000 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0.107540 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.222866 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.127386 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENT 0.181259 73. 00 73. 01 07301 HOSPI TAL BASED RETAIL PHARMACIES 1.282899 73. 01 74. 00 07400 RENAL DI ALYSI S 0.488773 74. 00 76. 00 03160 CARDI OPULMONARY 0.000000 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.231130 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.108906 77. 00 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0.000000 77. 00 78. 00 07800 CAR T -CELL I MMUNOTHERAPY 0.000000 77. 00 79. 01 09000 CLI NI C 0.683359 90. 02 790. 02 09002 PAIN C LI NI C 0.683359 90. 02 790. 03 09003 ONCOLOGY C LI NI C 0.683359 90. 02 790. 09 09000 DISSERVATI ON BEDS (NON-DISTINCT PART) 0.198447 91. 00 79. 01 09201 09SERVATI ON BEDS (DISTINCT PART) 0.198447 92. 00 79. 01 09201 09SERVATI ON BEDS (DISTINCT PART) 0.198447 92. 00 79. 01 09201 09SERVATI ON BEDS (DISTINCT PART) 0.244414 79. 01 09201 09500 AMBULANCE SERVI CES 0.000000 70. 01 09000 DISTINES REVICES 0.000000 70. 01 09000 ODESERVATI ON BEDS (DISTINCT PART) 0.244414 70. 01 09000 00000 00000 000000 000000 000000						
69. 00						
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72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0. 127386 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 181259 73. 00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 1. 282899 73. 01 73. 01 74. 00 07400 RENAL DIALYSIS 0. 488773 74. 00 76. 00 03160 CARDI OPULMONARY 0. 000000 76. 00 76. 97 CARDI AC REHABI LITATI ON 0. 231130 76. 97 76. 98 07697 CARDI AC REHABI LITATI ON 0. 231130 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 7700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 07800 CAR T-CELL I IMMUNOTHERAPY 0. 1000000 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0. 0000000 78. 00 07800 CLI NI C 0. 683359 0. 000000 090. 01 09001 SUBSTANCE ABUSE CLI NI C 0. 683359 0. 000000 090. 02 09002 PAI N CLI NI C 0. 683359 0. 000000 090. 01 09001 DEMERGENCY 0. 124579 0. 095191 0. 09100 DEMERGENCY 0. 095191 0. 095100 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 198447 0. 200 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 244414 0. 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 2000 0. 000000 0. 000000000000						
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73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 1. 282899 73. 01 74. 00 07400 RENAL DI ALYSIS 0. 488773 74. 00 07400 RENAL DI ALYSIS 0. 488773 74. 00 07600 03160 CARDI OPULMONARY 0. 000000 076. 97 07697 CARDI AC REHABI LITATI ON 0. 231130 76. 97 0769						
74. 00 07400 RENAL DIALYSIS 0.488773 76. 00 76. 00 03160 CARDI OPULMONARY 0.000000 76. 76. 70 76. 97 07697 CARDI OPULMONARY 0.000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.108906 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 77. 00 0017PATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 90.00000 90. 01 09001 SUBSTANCE ABUSE CLI NI C 1.636075 90. 02 90. 01 09001 SUBSTANCE ABUSE CLI NI C 1.636075 90. 02 90. 02 09002 PAI N CLI NI C 0.683359 90. 02 90. 03 09003 ONCOLOGY CLI NI C 0.124579 90. 03 91. 00 09100 EMERGENCY 0.09519 91. 00 92. 01 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 0.198447 92. 00 92. 01 09201 DESERVATI ON BEDS (DISTINCT PART) 0.244414 92. 01 07HER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0.000000 95. 00 102. 00 10200 OPI OI DI TREATMENT PROGRAM 9ECI AL PURPOSE COST CENTERS 113. 00 11300 I INTEREST EXPENSE 113. 00 200. 00 Subservati on Beds 200. 00 201. 00 Less Observati on Beds 201. 00						
76. 00						
76. 97 07697 CARDI AC REHABILITATION 0. 231130 76. 97 76. 98 776. 98 776. 98 776. 98 776. 98 776. 98 777. 00 7770 0. 77700 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.						
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78. 00						
OUTPATI ENT SERVICE COST CENTERS O. 000000 O. 0000000 O. 000000 O. 0000000 O. 0000000 O. 0000000 O. 00000000 O. 0000000 O. 00000000 O. 00000000 O. 000000000 O. 00000000 O. 00000000 O. 00000000 O. 00000000 O. 0000000000			1			
90. 00			0. 000000			/8.00
90. 01 09001 SUBSTANCE ABUSE CLINIC 1. 636075 90. 02 90. 02 90. 02 90. 02 90. 03 09003 0000LOGY CLINIC 0. 683359 90. 03 90. 03 90. 03 09003 0000LOGY CLINIC 0. 124579 90. 03 90. 00			0.00000			
90. 02						
90. 03						
91. 00			1 1			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 198447 92. 00 09201 0BSERVATI ON BEDS (DISTINCT PART) 0. 244414 92. 01 07HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 00 10200 0PI OI D TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 201. 00						
92. 01						
OTHER REIMBURSABLE COST CENTERS	4		1			
95. 00 09500 AMBULANCE SERVICES 0.000000 102.00 10200 0PI 0I D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00			0. 244414			92. 01
102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00			1			
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00	4		0. 000000			
113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00						102. 00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00						
201.00 Less Observation Beds 201.00						
	200.00	Subtotal (see instructions)				200. 00
202.00 Total (see instructions)	201.00	Less Observation Beds				201. 00
	202.00	Total (see instructions)				202. 00

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time | Prepared: Provider CCN: 15-0089

				То	12/31/2023	Date/Time Pre 5/24/2024 9:2	
			Ti tl	e XIX	Hospi tal	PPS	ı uıı
	Cost Center Description	Total Cost	Capital Cost	Operating Cost		Operating Cost	
	'	(Wkst. B, Part		Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1		1	_	_	
50.00	05000 OPERATI NG ROOM	25, 868, 968			0	0	
51.00	05100 RECOVERY ROOM	5, 062, 850			0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 823, 438			0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	27, 920, 913			0	0	54. 00 57. 00
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 559, 524	78, 185 0	1 ' '	0	0	
59. 00	05900 CARDIAC CATHETERIZATION	8, 330, 114	572, 677		0	0	59.00
60.00	06000 LABORATORY	22, 826, 680			0	0	60.00
60. 01	06001 BLOOD LABORATORY	22, 020, 000	700,094		0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 777, 703	-		0	0	63.00
65. 00	06500 RESPIRATORY THERAPY	7, 618, 150			0	0	65.00
65. 01	06501 SLEEP LAB	1, 060, 400			0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	10, 257, 666			0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 836, 230			0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 023, 178			0	0	68. 00
68. 01	06801 AUDI OLOGY	0	0		0	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	5, 299, 977	609, 336	4, 690, 641	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 252, 221	314, 565		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	19, 864, 813	265, 200	19, 599, 613	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	74, 138, 068	349, 782	73, 788, 286	0	0	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	28, 084, 505	222, 584	27, 861, 921	0	0	73. 01
74.00	07400 RENAL DIALYSIS	2, 117, 044	109, 596	2, 007, 448	0	0	74. 00
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 669, 121	7, 995		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 634, 096	30, 494	2, 603, 602	0	0	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0		0	0	
90. 01	09001 SUBSTANCE ABUSE CLINIC	1, 212, 376			0	0	90. 01
90. 02	09002 PAIN CLINIC	2, 327, 817	816, 730		0	0	90. 02
90. 03	09003 ONCOLOGY CLINIC	6, 479, 513			0	0	90. 03
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	27, 659, 326			0	0	91.00
92. 00 92. 01	09201 OBSERVATION BEDS (NON-DISTINCT PART)	12, 976, 588			0	0	92. 00 92. 01
92.01	OTHER REIMBURSABLE COST CENTERS	2, 124, 759	169, 266	1, 955, 493	U	U	92.01
95. 00	09500 AMBULANCE SERVICES	54, 611	25, 891	28, 720	0	0	95. 00
	10200 OPI OI D TREATMENT PROGRAM	0			0		102.00
102.00	SPECIAL PURPOSE COST CENTERS			· · · ·	<u> </u>	0	102.00
113 00	11300 I NTEREST EXPENSE						113. 00
200.00		333, 860, 649	12, 909, 115	320, 951, 534	0	n	200.00
201.00		12, 976, 588			0		201.00
202.00		320, 884, 061			0		202. 00
		,					

Health Financial Systems BALL MEMO CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF In Lieu of Form CMS-2552-10 BALL MEMORIAL HOSPITAL Provider CCN: 15-0089

Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am REDUCTIONS FOR MEDICALD ONLY

						5/24/2024 9: 21 am
				e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
		Operating Cost			6	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS			1		
	05000 OPERATING ROOM	25, 868, 968				50. 00
	05100 RECOVERY ROOM	5, 062, 850				51. 00
	05200 DELIVERY ROOM & LABOR ROOM	7, 823, 438		1		52. 00
	05400 RADI OLOGY-DI AGNOSTI C	27, 920, 913	270, 311, 674	0. 10329	92	54. 00
	05700 CT SCAN	3, 559, 524	57, 392, 281			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000	00	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	8, 330, 114	128, 463, 185	0. 06484	14	59.00
	06000 LABORATORY	22, 826, 680	122, 622, 894	0. 18615	53	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	00	60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 777, 703	7, 647, 350	0. 23246	50	63. 00
65.00	06500 RESPI RATORY THERAPY	7, 618, 150	32, 576, 084	0. 23385	57	65. 00
65. 01	06501 SLEEP LAB	1, 060, 400	9, 008, 836	0. 11770)7	65. 01
66. 00	06600 PHYSI CAL THERAPY	10, 257, 666	24, 990, 967	0. 41045	55	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 836, 230		0. 24176	3	67. 00
	06800 SPEECH PATHOLOGY	1, 023, 178				68. 00
68. 01	06801 AUDI OLOGY	0		1	00	68. 01
	06900 ELECTROCARDI OLOGY	5, 299, 977	49, 283, 823			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 252, 221				71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	19, 864, 813				72. 00
	07300 DRUGS CHARGED TO PATIENTS	74, 138, 068				73. 00
	07301 HOSPITAL BASED RETAIL PHARMACIES	28, 084, 505		1		73. 01
	07400 RENAL DIALYSIS	2, 117, 044				74.00
	03160 CARDI OPULMONARY	0		1		76.00
	07697 CARDI AC REHABI LI TATI ON	1, 669, 121	1			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	2, 634, 096		1		76. 98
	07700 ALLOGENEIC HSCT ACQUISITION	2,001,070	21, 100, 077	1		77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	ĺ	1		78. 00
	OUTPATIENT SERVICE COST CENTERS			0.00000	70	76.00
	09000 CLINIC	0	0	0.00000	10	90.00
	09001 SUBSTANCE ABUSE CLINIC	1, 212, 376	1	1		90. 01
	09002 PAIN CLINIC	2, 327, 817	l ·	1		90. 02
	09003 ONCOLOGY CLINIC	6, 479, 513				90. 03
	09100 EMERGENCY	27, 659, 326	l '			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 976, 588				92.00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	1		1		92.00
	OTHER REIMBURSABLE COST CENTERS	2, 124, 759	8, 693, 279	0. 24441	4	92.01
	09500 AMBULANCE SERVICES	E / 411		0.00000)O	0F 00
		54, 611	0	1		95. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0.00000	<i>1</i> 0	102. 00
	SPECIAL PURPOSE COST CENTERS			I		112.00
	11300 INTEREST EXPENSE	222 0/0 /42	0 1/5 / 41 045			113. 00
200.00	, , ,		2, 165, 641, 315	1		200. 00
201.00		12, 976, 588		1		201. 00
202.00	Total (line 200 minus line 201)	320, 884, 061	2, 165, 641, 315	1		202. 00

Health Financial Systems	BALL MEMORIA	J HOSPLTAL		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part I	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		•	<u> </u>		
30. 00 ADULTS & PEDIATRICS	7, 302, 158	0	7, 302, 15	8 70, 925	102. 96	30.00
31.00 INTENSIVE CARE UNIT	1, 136, 572		1, 136, 57	2 8, 360	135. 95	31. 00
32.00 CORONARY CARE UNIT	0			0		
35.00 NEONATAL INTENSIVE CARE UNIT	354, 977		354, 97	7 2, 923		
40. 00 SUBPROVI DER - I PF	0	0		0		
41. 00 SUBPROVI DER - I RF	456, 222	0	456, 22			
43. 00 NURSERY	188, 039	l e	188, 03	· ·		43. 00
200.00 Total (lines 30 through 199)	9, 437, 968		9, 437, 96	89, 282		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	/ 00	6)				
INDATIONE DOUTING CODYLOG COST CONTEDS	6. 00	7. 00				
30. 00 ADULTS & PEDIATRICS	18, 938	1, 949, 856				30.00
31. 00 INTENSIVE CARE UNIT	2, 280		•			31.00
32. 00 CORONARY CARE UNIT	2, 200	309, 900				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	1, 917	180, 466				41.00
43. 00 NURSERY	1, 717	100,400				43.00
200.00 Total (lines 30 through 199)	23, 135	2, 440, 288				200. 00

Health Financial Systems	BALL MEMORIAL H	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERV	ICE CAPITAL COSTS	Provi der CCN: 15-0089	Peri od: From 01/01/2023	Worksheet D Part II

Health Financial Systems	BALL MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2023	Part II	
				To 12/31/2023		pared:
					5/24/2024 9: 2	<u> 1 am </u>
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		I npati ent	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 458, 982	240, 203, 943	0. 00607	4 33, 439, 485	203, 111	50.00
51. 00 05100 RECOVERY ROOM	326, 446	33, 076, 241	0. 00987	0 2, 915, 250	28, 774	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	467, 104	29, 529, 990	0. 01581	8 189, 279	2, 994	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 368, 683		1			54.00
57. 00 05700 CT SCAN	78, 185		1			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	70,100		0. 00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	572, 677	_	1		1	59. 00
60. 00 06000 LABORATORY	708, 094		l .		1	60.00
60. 01 06001 BLOOD LABORATORY	700,074		0.00000		1	60. 01
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	3, 750	_				63. 00
65. 00 06500 RESPIRATORY THERAPY	1		1		48, 950	
	208, 134					1
	5, 308				l .	65. 01
66. 00 06600 PHYSI CAL THERAPY	684, 097				57, 391	1
67. 00 06700 OCCUPATI ONAL THERAPY	93, 585		1			67. 00
68. 00 06800 SPEECH PATHOLOGY	24, 697				1	68. 00
68. 01 06801 AUDI 0L0GY	0	_	0. 00000			68. 01
69. 00 06900 ELECTROCARDI OLOGY	609, 336		1		85, 511	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	314, 565	99, 845, 529			38, 801	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	265, 200	155, 942, 276	0. 00170	1 32, 808, 195	55, 807	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	349, 782	409, 017, 958			25, 314	73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	222, 584			8 0	0	73. 01
74. 00 07400 RENAL DIALYSIS	109, 596	4, 331, 344	0. 02530	3 1, 155, 591	29, 240	74. 00
76. 00 03160 CARDI OPULMONARY	0	0	0.00000	0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	7, 995	7, 221, 569	0. 00110	7 455, 448	504	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	30, 494	24, 186, 899	0. 00126	1 75, 293	95	76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION			0. 00000		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1		0	78. 00
OUTPATIENT SERVICE COST CENTERS		-		-		
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC	234, 756					90. 01
90. 02 09002 PAIN CLINIC	816, 730		1		1	90. 02
90. 03 09003 0NCOLOGY CLINIC	294, 893					1
91. 00 09100 EMERGENCY	1, 380, 125		1		123, 212	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						91.00
	1, 078, 160				l	l
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	169, 266	8, 693, 279	0. 01947	1 31, 622	616	92. 01
OTHER REIMBURSABLE COST CENTERS						05 00
95. 00 09500 AMBULANCE SERVICES	10 000 004	0 1/5 /41 015		214 257 225	1 004 707	95. 00
200.00 Total (lines 50 through 199)	12, 883, 224	2, 165, 641, 315	1	214, 256, 285	1, 024, 736	J200. 00

Health Financial Systems	BALL MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	rs Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/24/2024 9:2	pared: 1 am
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	171	1.00		2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0		0 0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0 0	0	35. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	1	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
LANDATI ENT. DOUTLAND DEDVILOS COOT OFFITEDO	4. 00	5. 00	6.00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			70.00		40.000	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0					1
31. 00 03100 I NTENSI VE CARE UNI T		0	-,		2, 280	1
32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT		0		0. 00 3 0. 00	0	
40. 00 04000 SUBPROVI DER - 1 PF	0	0	1	0.00	0	
41. 00 04100 SUBPROVI DER - 1 FF	0	0			1, 917	
43. 00 04300 NURSERY	0	0			1, 717	1
200.00 Total (lines 30 through 199)	•	0	_,			200. 00
Cost Center Description	I npati ent	Ü	07,20		20, 100	200.00
oust content besoft per on	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
31. 00 03100 INTENSIVE CARE UNIT	0					31. 00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
40. 00 04000 SUBPROVI DER - 1 PF	0					40. 00
41. 00 04100 SUBPROVI DER - RF	0					41.00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0					200. 00

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

From 01/01/2023 | Part IV To 12/31/2023 | Date/Time Prepared: THROUGH COSTS 5/24/2024 9: 21 am Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Cost Post-Stepdown Adi ustments Adjustments 1.00 3. 00 2A 2.00 ЗА ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 00000000000000000000000000000000 0 05100 RECOVERY ROOM 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 05700 CT SCAN 0 57.00 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 60.00 06000 LABORATORY 0 0 60.00 Oi 06001 BLOOD LABORATORY 0 60.01 60.01 Λ 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 65.00 0 0 65.01 06501 SLEEP LAB 65.01 0 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0 68.00 0 06801 AUDI OLOGY 0 68.01 68 01 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 333, 894 73 00 73 00 0 73.01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 03160 CARDI OPULMONARY 0 76.00 0 76.00 0 07697 CARDIAC REHABILITATION 0 0 76.97 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 0 09001 SUBSTANCE ABUSE CLINIC 90.01 0 0 0 0 0 0 90.01 0 90. 02 09002 PAIN CLINIC 0 90. 02 0 09003 ONCOLOGY CLINIC 0 90.03 0 0 0 90.03 09100 EMERGENCY 0 91.00 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 0 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES

0

0

0

0

333, 894 200. 00

200.00

Health Financial Systems	BALL MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0089	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

THROUGH COSTS 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am Title XVIII Hospi tal All Other Cost Center Description Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 8) 4) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 240, 203, 943 0.000000 50.00 00000000000000000000000000000 51.00 05100 RECOVERY ROOM 0 0 33, 076, 241 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 29, 529, 990 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 270, 311, 674 0.000000 54 00 57.00 05700 CT SCAN 0 0 57, 392, 281 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 128, 463, 185 0.000000 59 00 0 60.00 06000 LABORATORY 0 122, 622, 894 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 7, 647, 350 0.000000 63.00 06500 RESPIRATORY THERAPY 32, 576, 084 0 000000 65 00 65 00 65.01 06501 SLEEP LAB 9, 008, 836 0.000000 65.01 06600 PHYSI CAL THERAPY 24, 990, 967 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 7, 595, 158 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY Ω 4, 460, 826 0.000000 68 00 68.01 06801 AUDI OLOGY 0 0.000000 68.01 06900 ELECTROCARDI OLOGY 49, 283, 823 0.000000 69.00 69.00 99, 845, 529 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENT O 155, 942, 276 72 00 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 333, 894 333, 894 409, 017, 958 0.000816 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 21, 891, 431 0.000000 73.01 0 73.01 07400 RENAL DIALYSIS 74.00 0 4, 331, 344 0.000000 74.00 0 03160 CARDI OPULMONARY 0 0.000000 76.00 C 76 00 76. 97 07697 CARDIAC REHABILITATION 0 0 7, 221, 569 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 24, 186, 899 0.000000 76. 98 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 77.00 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0 0 0.000000 90.00 0 90.01 09001 SUBSTANCE ABUSE CLINIC 0 741, 027 0.000000 90 01 C 0 90.02 09002 PAIN CLINIC 3, 406, 435 0.000000 90.02 0 09003 ONCOLOGY CLINIC 90. 03 0 0 52, 011, 215 0.000000 90.03 09100 EMERGENCY 91.00 0 295, 798, 266 0.000000 91.00 C 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 65, 390, 835 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 8, 693, 279 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00

0

333, 894

333, 894 2, 165, 641, 315

200.00

200.00

Health Financial Systems BALL MEMORIAL F		HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0089	Peri od:	Worksheet D

From 01/01/2023 | Part IV To 12/31/2023 | Date/Time Prepared: THROUGH COSTS 5/24/2024 9: 21 am Title XVIII Hospi tal PPS Inpati ent Outpati ent Cost Center Description Outpati ent Inpatient Outpati ent Program Ratio of Cost Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 33, 439, 485 22, 182, 366 50.00 0 05100 RECOVERY ROOM 0 51.00 0.000000 2, 915, 250 4, 535, 673 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 189, 279 0 52.00 1,536 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 13, 927, 322 0 53, 682, 560 54.00 0 54.00 05700 CT SCAN 0.000000 57.00 0 6, 791, 776 57.00 7, 106, 246 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 17, 628, 869 21, 599, 103 0 59.00 06000 LABORATORY 0.000000 0 6, 120, 289 60 00 15, 340, 033 0 60 00 06001 BLOOD LABORATORY 0 60.01 0.000000 0 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 0.000000 1, 671, 549 401, 328 0 63.00 06500 RESPIRATORY THERAPY 65.00 0.000000 7, 661, 681 0 753, 306 0 65.00 06501 SLEEP LAB 0 0.000000 1, 549, 258 65 01 6, 118 0 65 01 66.00 06600 PHYSI CAL THERAPY 0.000000 2, 096, 537 62, 965 0 66.00 06700 OCCUPATIONAL THERAPY 695, 506 67.00 0.000000 74 0 67.00 06800 SPEECH PATHOLOGY 68 00 0.000000 864, 654 5, 266 0 68 00 68.01 06801 AUDI OLOGY 0.000000 0 0 68.01 69.00 06900 ELECTROCARDI OLOGY 0.000000 6, 916, 121 0 7, 732, 271 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 12, 313, 976 0 16, 954, 866 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENT 17, 677, 004 72 00 0.000000 32, 808, 195 O 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000816 29, 606, 581 24, 159 101, 531, 297 82, 850 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 0.000000 0 73.01 74.00 07400 RENAL DIALYSIS 0.000000 1, 155, 591 0 40, 857 0 74.00 03160 CARDI OPULMONARY 0.000000 0 76.00 76.00 0 76.97 07697 CARDIAC REHABILITATION 0.000000 455, 448 0 1, 945, 094 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 6, 289, 340 0 76. 98 76.98 75, 293 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0.000000 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 90 00 0.000000 90.01 09001 SUBSTANCE ABUSE CLINIC 0.000000 0 10, 720 0 90.01 0 09002 PAIN CLINIC 90.02 90 02 0.000000 6, 184 743,076 0 90.03 09003 ONCOLOGY CLINIC 0.000000 519, 543 20, 135, 085 90.03 91.00 09100 EMERGENCY 0.000000 26, 406, 441 0 24, 263, 829 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 418, 761 0 92.00 0.000000 6, 477, 138 0 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 31,622 1,044,422 92.01 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

214, 256, 285

24, 159

322, 530, 499

82, 850 200. 00

200.00

Heal th	Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0089	Peri od:	Worksheet D	
					From 01/01/2023	Part V	
					To 12/31/2023	Date/Time Pre	
			Ti +l c	e XVIII	Hospi tal	5/24/2024 9: 2 PPS	ı allı
			11116	Charges	HOSPI tai	Costs	
	Cost Center Description	Cost to Charge	DDS Daimhursad		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(366 11131.)	
		Part I, col. 9		Subject To	Subject To		
		1 41 6 1, 661. 7		Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATI NG ROOM	0. 107696	22, 182, 366	,	0 0	2, 388, 952	50.00
51. 00	05100 RECOVERY ROOM	0. 153066			o o	694, 257	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 264932	1, 536		0 0	407	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 103292				5, 544, 979	
57. 00	05700 CT SCAN	0. 103272	6, 791, 776		0 0	421, 233	
			0, 791, 770	3	0 0		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	21 500 102			1 400 573	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 064844	21, 599, 103		0	1, 400, 572	
60.00	06000 LABORATORY	0. 186153			0 0	1, 139, 310	
60. 01	06001 BLOOD LABORATORY	0. 000000)	0 0	0	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 232460		1	0 0	93, 293	1
65. 00	06500 RESPI RATORY THERAPY	0. 233857	753, 306		0	176, 166	
65. 01	06501 SLEEP LAB	0. 117707	1, 549, 258	1	0 0	182, 359	1
66. 00	06600 PHYSI CAL THERAPY	0. 410455		1	0	25, 844	1
67.00	06700 OCCUPATI ONAL THERAPY	0. 241763		·	0 0	18	
68.00	06800 SPEECH PATHOLOGY	0. 229370	5, 266		0 0	1, 208	68. 00
68. 01	06801 AUDI OLOGY	0. 000000	0		0 0	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	0. 107540	7, 732, 271		0 0	831, 528	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 222866	16, 954, 866		o o	3, 778, 663	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 127386	17, 677, 004	ļ	o o	2, 251, 803	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 181259	101, 531, 297	50	71, 309	18, 403, 461	73.00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	1. 282899			ol o	0	73. 01
74. 00	07400 RENAL DIALYSIS	0. 488773	40, 857	,	o o	19, 970	
76. 00	03160 CARDI OPULMONARY	0. 000000			o o	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 231130	l e	i		449, 570	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 108906				684, 947	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			o o	001,717	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			o o	0	
70.00	OUTPATIENT SERVICE COST CENTERS	0.00000		1	9 9		70.00
90. 00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	1. 636075		1	o o	17, 539	
90. 02	09002 PAIN CLINIC	0. 683359		1		507, 788	
90. 02	09003 ONCOLOGY CLINIC	0. 124579		1		2, 508, 409	
91. 00	09100 EMERGENCY	0. 124374	24, 263, 829	1	0 1, 535	2, 268, 838	1
91.00		0. 198447			0 1, 555		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0 0	1, 285, 369	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 244414	1, 044, 422	<u> </u>	U U	255, 271	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS	0.000000					05 00
95.00	09500 AMBULANCE SERVICES	0. 000000	ł .		0 72 044	4E 004 7E4	95. 00
200.00			322, 530, 499	50		45, 331, 754	
201.00					0 0	ı	201. 00
202. 00	Only Charges Net Charges (line 200 - line 201)		222 520 400	50	72 044	45, 331, 754	202 00
202.00	inet charges (Time 200 - Time 201)	I	322, 530, 499	ıl ər	72, 844	40, 331, 754	1202.00

Health Financial Systems BALL MEMORIA APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0089

Cost Center Description				10 12/31/2023	Date/Time Prepared: 5/24/2024 9:21 am
Cost Center Description			Title XVII	I Hospi tal	
Cost Center Description		Costs		1 110361 tai	11.5
Reinbursed Services Subject To Ded. & Coins Services Not Subject To Ded. & Coins Services Not Subject To Ded. & Coins Su	Cost Center Description				
Services Subject To Dod. & Coins. Code. Code. & Coins. Code.	0001 0011101 20001 1 211 011				
Subject To Ded. & Coins. Subject To Ded. & Coins. Soe Inst.) Subject To Ded. & Coins. Subject To Sub					
Decl. & Coins. See Inst. (See Inst. Cost Inst.					
ANCILLARY SERVICE COST CENTERS 7,00 50,00					
ANCILLARY SERVICE COST CENTERS					
50.00 05000 05000 0 0 0 0					
51.00 05100 RECOVERY ROOM 0 0 0 52.00 0520 0 0520 0 0520 0 0520 0 0520 0 0520 0 0 0 0 0 0 0 0 0	ANCILLARY SERVICE COST CENTERS		·		
S2_00 05200 DELIVERY ROOM & LABOR ROOM 0 0 54.00 54.00 54.00 55.00 65.00	50. 00 05000 OPERATI NG ROOM	0	0		50. 00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 57.00	51.00 05100 RECOVERY ROOM	o	O		51. 00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 57.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	o	O		52. 00
58.00 05900 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0		o	0		54. 00
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 05700 CT SCAN	o	0		57. 00
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	O		58. 00
60.00 66000 LABORATORY 0 0 0 0 66.00 63.00 06300 BLOOD LABORATORY 0 0 0 0 63.00 65.00 06500 BLOOD LABORATORY 0 0 0 0 63.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 65.01 06501 SLEEP LAB 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67.00 06700 0CCUPATI JONAL THERAPY 0 0 0 0 68.00 06800 SPECCH PATHOLOGY 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 69.00 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 92 12,925 73.00 73.01 073301 MOSPITAL BASED RETAIL PHARMACIES 0 0 0 74.00 74.00 07400 RENAL DIALYSIS 74.00 75.00 75.00 07400 RENAL DIALYSIS 0 0 0 74.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.97 77.00 07700 ALLOGENICI C HISTORY 0 0 0 77.00 77.00 07700 ALLOGENICI C HIST C ACQUISITION 0 0 0 78.00 07800 CART T-CELL I IMMINOTHERAPY 0 0 0 0 79.00 07900 DAGORAT T-CELL I IMMINOTHERAPY 0 0 0 0 79.01 09001 SUBSTANCE ABUSE CLINIC 0 0 0 0 79.02 PAIN CLINIC 0 0 0 79.03 09002 PAIN CLINIC 0 0 0 79.04 09002 PAIN CLINIC 0 0 0 79.05 09000 PAIN CLINIC 0 0 0 79.07 07000 07000 EMERGENCY 0 0 0 79.08 07000 07000 07000 07000 79.09 07000 07000 07000 07000 07000 79.00 07000 07000 07000 07000 79.00 07000 07000 07000 07000 79.00 07000 07000 07000 07000 79.00 07000 07000 07000 07000 79.00 07000 07000 07000 07000 79.00 07000 07000 07000 79.00 07000 07000 07000 07000 79.00 07000 07000 07000 79.00 07000 07000 07000 79.00 07000 07000		o	O		59.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 0 0 0 0 0 0		o	O		
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0	60. 01 06001 BLOOD LABORATORY	o	O		60. 01
65. 01 06501 SLEEP LAB	63.00 06300 BLOOD STORING, PROCESSING, & TRANS	i. o	o		63. 00
65. 01 06501 SLEEP LAB		o	O		65. 00
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 67. 00 677. 00 06700 06700 06700 06700 068. 00 06800 06800 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 01 06801 AUDI OLOGY 0 0 0 0 0 68. 01 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 RUISC CHARGED TO PATI ENTS 92 12, 925 73. 00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 76. 00 03160 CARDI DULLMONARY 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUI SITI ON 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 79. 00 07900 CAR T-CELL IMMUNOTHERAPY 0 0 90. 01 09001 SUBSTANCE ABUSE CLINI C 0 0 90. 02 09002 PAIN CLINI C 0 0 90. 03 09003 ONCOLOGY CLINI C 0 0 90. 04 09001 SUBSTANCE ABUSE CLINI C 0 0 90. 05 09000 PAIN ACCURATION BEDS (NON-DISTINCT PART) 0 0 91. 00 09001 UBRERGENCY 0 144 91. 00 92. 00 09200 DSERVATI ON BEDS (NON-DISTINCT PART) 0 0 92. 00 09200 SUBSTRANCE SERVI CES 0 90. 00 Subtotal (see instructions) 92 13,069 200. 00 Subtotal (see instructions) 92 13,069 201. 00 Call Substance Call Substa		o	O		65. 01
88. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 01 68. 01 06801 AUDI OLOGY 0 0 0 0 68. 01 06801 AUDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 92 12,925 73. 00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 76. 00 03160 CARDI OPULMONARY 0 0 0 76. 97 07697 CARDI AC REHABILLITATI ON 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 79. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 79. 01 09001 SUBSTANCE ABUSE CLINIC 0 0 0 79. 02 09002 PAIN IN CLINIC 0 0 0 79. 03 09003 ONCOLOGY CLINIC 0 0 0 79. 00 09001 DERREENCY 0 0 0 79. 00 09002 DERREENCY 0 0 0 79. 00 09001 DERREENCY 0 0 79. 00 09001 DERREENCY 0 0 79. 00 09002 DERREENCY 0 0 79. 00 09001 DREENCENCY 0 0 79. 00 09001 DREENCENCY 0 0 79. 00 09001 DREENCENCY 0		o	o		66. 00
68. 01	67. 00 06700 OCCUPATI ONAL THERAPY	o	o		67. 00
69. 00	68. 00 06800 SPEECH PATHOLOGY	o	o		68. 00
69.00 66900 ELECTROCARDIOLOGY 0 0 0 69.00 71.00 771.00 771.00 771.00 771.00 771.00 771.00 771.00 771.00 771.00 771.00 771.00 772.00	68. 01 06801 AUDI OLOGY	o	o		68. 01
72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0		o	o		69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 73. 00 73. 00 73.00 DRUGS CHARGED TO PATIENTS 92 12, 925 73. 01 73.01 10.591 TAL BASED RETAIL PHARMACIES 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	ITS 0	o		71. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 0 7400 RENAL DILALYSIS 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 7400 RENAL DILALYSIS 0 0 0 0 0 7500 RENAL DILALYSIS 0 0 0 0 0 0 0 7700 RENAL DILALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		o	o		72. 00
74. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	92	12, 925		73. 00
76. 00	1	o			73. 01
76. 97		o	o		74. 00
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 0 0	76. 00 03160 CARDI OPULMONARY	o	O		76. 00
77. 00	76. 97 07697 CARDI AC REHABI LI TATI ON	o	O		76. 97
78. 00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	O		76. 98
OUTPATIENT SERVICE COST CENTERS O	77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	O		77. 00
90. 00 09000 CLINIC 00 0 0 0 0 0 0 0 0	78.00 07800 CAR T-CELL IMMUNOTHERAPY	o	O		78. 00
90. 01 09001 SUBSTANCE ABUSE CLINIC 0 0 0 90. 01 90. 02 09002 PAIN CLINIC 0 0 0 90. 02 90. 03 09003 0NCOLOGY CLINIC 0 0 0 0 91. 00 09100 EMERGENCY 0 144 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 92. 01 OTHER REIMBURSABLE COST CENTERS 95. 00 95. 00 09500 AMBULANCE SERVICES 0 200. 00 Subtotal (see instructions) 92 13, 069 201. 00 Cless PBP Clinic Lab. Services-Program 0 001 y Charges 0 001 001 OTHER REIMBURSABLE COST CENTERS 0 001 001 001 001 001 002 003 005 005 005 005 005 005 005 005 005 006 007 007 007 007 007 007 007 007 007 008 007 007 007 007 009 007 007 007 009 009 007 007 007 009	OUTPATIENT SERVICE COST CENTERS		·		
90. 02 09002 PAIN CLINIC 0 0 0 0 90. 02 90. 03 09003 0NCOLOGY CLINIC 0 0 0 0 0 90. 03 91. 00 09100 EMERGENCY 0 0 144 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 09200 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	0	0		90. 00
90. 03 09003 0NCOLOGY CLINIC 0 0 0 90. 03 91. 00 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	90. 01 09001 SUBSTANCE ABUSE CLINIC	o	0		90. 01
91. 00 09100 EMERGENCY 0 144 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	90. 02 09002 PAIN CLINIC	o	O		90. 02
91. 00 09100 EMERGENCY 0 144 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	90. 03 09003 0NCOLOGY CLINIC	o	O		90. 03
92. 00 99200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0		o	144		91. 00
92. 01 09201 08SERVATI ON BEDS (DISTINCT PART) 0 0 0 92. 01		(T)	O		92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 200. 00 201. 00 Subtotal (see i nstructions) Less PBP Clinic Lab. Services-Program Only Charges OTHER REIMBURSABLE COST CENTERS 0 95. 00					
95. 00			<u>'</u>		
200.00 Subtotal (see instructions) 92 13,069 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00		O			95. 00
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 0 201.00	· · · · · · · · · · · · · · · · · · ·	92	13, 069		200. 00
Only Charges		1			
202.00 Net Charges (line 200 - line 201) 92 13,069 202.00					
	202.00 Net Charges (line 200 - line 201)	92	13, 069		202. 00

APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider Component (Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/24/2024 9:2	pared:
			Title	XVIII	Subprovi der - I RF	PPS	. i aiii
	Cost Center Description	Capi tal	Total Charges		I npati ent	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	F 00	
	ANGLEL ADV. CEDVI CE. COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 450 000	240 202 042	0. 00607	4 78, 389	477	- 00
50.00		1, 458, 982				476	
51.00	05100 RECOVERY ROOM	326, 446		0.00987		116	
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM	467, 104				0 1, 748	
54.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	2, 368, 683 78, 185		0.00876		1, 748	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	/8, 185		1		90	
59. 00	05900 CARDIAC CATHETERIZATION	572, 677	-			7	
60.00	06000 LABORATORY	708, 094				1, 877	
60. 00	06001 BLOOD LABORATORY	700,094				1, 6//	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	3, 750				3	
65. 00	06500 RESPIRATORY THERAPY	208, 134				368	
65. 01	06501 SLEEP LAB	5, 308				0	
66. 00	06600 PHYSI CAL THERAPY	684, 097				43, 667	
67. 00	06700 OCCUPATI ONAL THERAPY	93, 585				23, 100	1
68. 00	06800 SPEECH PATHOLOGY	24, 697				2, 899	
68. 01	06801 AUDI OLOGY	0				0	
	06900 ELECTROCARDI OLOGY	609, 336	49, 283, 823			609	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	314, 565				185	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	265, 200				19	
73. 00	07300 DRUGS CHARGED TO PATIENTS	349, 782	409, 017, 958	0. 00085	5 764, 850	654	73.00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	222, 584	21, 891, 431	0. 01016	8 0	0	73. 01
74. 00	07400 RENAL DIALYSIS	109, 596	4, 331, 344	0. 02530	3 72, 098	1, 824	74.00
76. 00	03160 CARDI OPULMONARY	0	0	0. 00000	o o	0	76.00
76. 97	07697 CARDIAC REHABILITATION	7, 995	7, 221, 569	0. 00110	7 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	30, 494	24, 186, 899	0. 00126	1 0	0	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0				0	
	09001 SUBSTANCE ABUSE CLINIC	234, 756				0	
90. 02	09002 PAIN CLINIC	816, 730				0	
90. 03	09003 ONCOLOGY CLINIC	294, 893				0	
91. 00	09100 EMERGENCY	1, 380, 125				0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,,			0	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	169, 266	8, 693, 279	0. 01947	1 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
05 00							1 0- 0-
95. 00 200. 00	09500 AMBULANCE SERVICES	11 005 67	2, 165, 641, 315		5, 695, 041	77, 642	95.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	BALL MEMORIA	S Provider CO	CN: 15-0089 CCN: 15-T089	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/24/2024 9:2	pared:
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program		Allied Health	
	1.00	2A	2. 00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	C			0 (
51. 00 05100 RECOVERY ROOM	C			0 0	1	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	C	0		0 0	1	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0		0 0	0	54.00
57. 00 05700 CT SCAN	(0)	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (59.00 05900 CARDIAC CATHETERIZATION	IRI)			0 0		58. 00 59. 00
60. 00 06000 LABORATORY						60.00
60. 01 06000 LABORATORY						60.00
63.00 06300 BLOOD STORING, PROCESSING, &	TRANS.	0			1	63.00
65. 00 06500 RESPIRATORY THERAPY	TRANS.	1				65.00
65. 01 06501 SLEEP LAB				0		65. 01
66. 00 06600 PHYSI CAL THERAPY		0		0	1	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		o o		o c	ol o	67. 00
68.00 06800 SPEECH PATHOLOGY	c	Ó		0	0	68. 00
68. 01 06801 AUDI OLOGY	c	0		0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	c	0		0 (0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO	PATI ENTS C	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIEN	4	1		0	1	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	1		0	1,	
73. 01 07301 HOSPITAL BASED RETAIL PHARMA	CIES	0		0 0		73. 01
74. 00 07400 RENAL DI ALYSI S	C	0		0 0	1	
76. 00 03160 CARDI OPULMONARY	C	1		0 0	1	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY		1			0	76. 97 76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		1		0 0	1	
78. 00 07700 ALEGGENETE TISET ACCOUNTY TO THE TOTAL TO						
OUTPATIENT SERVICE COST CENTERS		, 0	l	0	,, 0	70.00
90. 00 09000 CLINIC	C	0		0 0	0	90. 00
90. 01 09001 SUBSTANCE ABUSE CLINIC				o c	1	90. 01
90. 02 09002 PAIN CLINIC				o d	o	90. 02
90. 03 09003 ONCOLOGY CLINIC	c	0		0 0	0	90. 03
91. 00 09100 EMERGENCY	c	0		0 0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTIN)		0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT P	ART) C	0		0 (0	92. 01
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		ol o	l	0	333, 894	1200 00

Heal th	Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS		S Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
			Title	XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	ANOLULARY OFRICAS COOT OFFITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1			0.40.000.040		
50. 00	05000 OPERATING ROOM	0	l e		0 240, 203, 943		
51. 00	05100 RECOVERY ROOM	0			0 33, 076, 241	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0 29, 529, 990		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 270, 311, 674		
57. 00	05700 CT SCAN	0			0 57, 392, 281	0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1		0 0	0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 128, 463, 185	l	
60.00	06000 LABORATORY	0	1		0 122, 622, 894		
60. 01	06001 BLOOD LABORATORY	0	0		0	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 7, 647, 350	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 32, 576, 084		
65. 01	06501 SLEEP LAB	0	0		0 9, 008, 836		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 24, 990, 967	0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 7, 595, 158	l	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0 4, 460, 826	l	1
68. 01	06801 AUDI OLOGY	0	0		0	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 49, 283, 823	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 99, 845, 529		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0			0 155, 942, 276		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	333, 894	333, 89			
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	0	0		0 21, 891, 431	0. 000000	1
74. 00	07400 RENAL DI ALYSI S	0	0		0 4, 331, 344	l	
76. 00	03160 CARDI OPULMONARY	0	0		0	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0			0 7, 221, 569		
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			0 24, 186, 899	0. 000000	
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0			0	0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS	_	_	T			
90.00	09000 CLINIC	0			0 0	0.000000	1
90. 01	09001 SUBSTANCE ABUSE CLINIC	0	1		0 741, 027	l	
90. 02	09002 PAIN CLINIC	0	1		0 3, 406, 435		
90. 03	09003 ONCOLOGY CLINIC	0	0		0 52, 011, 215		
91.00	09100 EMERGENCY	0			0 295, 798, 266		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1		0 65, 390, 835		
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 8, 693, 279	0.000000	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS	T					05 00
95. 00 200. 00	09500 AMBULANCE SERVICES	0	222 004	222.00	04 0 145 441 015		95.00
∠∪∪. UU	Total (lines 50 through 199)	1	333, 894	J 333, 89	2, 165, 641, 315	I	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	BALL MEMORIAL RVICE OTHER PASS	Provi der CO	CN: 15-0089	Peri od:	u of Form CMS-2 Worksheet D	2332-10
THROUGH COSTS		Component (CCN: 15-T089	From 01/01/2023 To 12/31/2023	Part IV Date/Time Prep 5/24/2024 9:2	
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col . 6 ÷ col . 7)		Costs (col. x col. 10)	5	Costs (col. 9 x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0.000000	78, 389		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	11, 760		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	11, 700		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	199, 474		0 0	0	
57. 00 05700 CT SCAN	0. 000000	66, 005			0	1
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000	0			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 576		ol ol	0	
60. 00 06000 LABORATORY	0. 000000	324, 952		o o	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		o o	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	5, 860		o o	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	57, 628		0 0	0	65. 00
65. 01 06501 SLEEP LAB	0. 000000	o		0 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 595, 201		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 874, 706		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	523, 594		0 0	0	68. 00
68. 01 06801 AUDI OLOGY	0. 000000	0		0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	49, 217		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	58, 644		0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	11, 087		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000816	764, 850	62		0	
73. 01 07301 HOSPI TAL BASED RETAIL PHARMACIES	0. 000000	0		0 0	0	
74. 00 07400 RENAL DI ALYSI S	0. 000000	72, 098		0	0	
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION	0. 000000 0. 000000	0		0 0	0	76. 98 77. 00
	0.000000	0		0 0	0	
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0.000000	U		0 0	0	78.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09000 CETNIC 90. 01 09001 SUBSTANCE ABUSE CLINIC	0. 000000	0		0 0	0	
90. 02 09002 PAIN CLINIC	0. 000000	0		0 0	0	90.01
90. 03 09003 0NCOLOGY CLINIC	0. 000000	0		0 0	0	
91. 00 09100 EMERGENCY	0. 000000	0		0 412	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
	0.000000	U		<u>υ</u> υ		1 /2.01
	•					
95. 00 09500 AMBULANCE SERVI CES						95. 00

		Component	CCN: 15-1089	0 12/31/2023	Date/lime Pre 5/24/2024 9:2	
		Title	: XVIII	Subprovi der -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
	1.00	0.00	(see inst.)	(see inst.)	F 00	
ANGLILLARY CERVILOE COCT CENTERC	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0. 107696	0			0	FO 00
51. 00 05100 RECOVERY ROOM	1			-	0	
l I	0. 153066		•			1
	0. 264932			_	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 103292		1	-	0	
57. 00 05700 CT SCAN	0. 062021	1		-	0	
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	0. 000000	0			0	
	0. 064844	1	1	-	0	
60. 00 06000 LABORATORY	0. 186153	0		-	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		-	0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 232460	1			0	63.00
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	0. 233857	0		-	0	00.00
	0. 117707		1	-	0	
66. 00 06600 PHYSI CAL THERAPY	0. 410455				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 241763	1		-	ū	1 07.00
68. 00 06800 SPEECH PATHOLOGY	0. 229370	0		-	0	
68. 01 06801 AUDI OLOGY	0. 000000			-	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 107540	1		_	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 222866	0			O	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 127386	0		-	0	1 00
73.00 O7300 DRUGS CHARGED TO PATIENTS 73.01 O7301 HOSPITAL BASED RETAIL PHARMACIES	0. 181259				0	1
	1. 282899			_	ŭ	1 , 0. 0 .
	0. 488773		1	-	0	
76. 00 03160 CARDI OPULMONARY	0. 000000	-			0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 231130			-	0	76. 97
	0. 108906				0	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000 0. 000000			-	0	
OUTPATIENT SERVICE COST CENTERS	0.00000) U		70.00
90. 00 09000 CLINI C	0. 000000	0		0	0	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC	1. 636075	0	1	-	0	
90. 02 09002 PAIN CLINIC	0. 683359	0		-	0	1
90. 03 09003 0NCOLOGY CLINIC	0. 124579	0		_	0	1
91. 00 09100 EMERGENCY	0. 093507	412		_	39	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 198447	0		-	0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 244414	0			0	
OTHER REIMBURSABLE COST CENTERS	0.211111			,		72.01
95. 00 09500 AMBULANCE SERVI CES	0. 000000					95. 00
200.00 Subtotal (see instructions)		412			39	200. 00
201.00 Less PBP Clinic Lab. Services-Program					0,	201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		412		2, 224	39	202. 00
	•	**************************************	•			•

Health Financial Systems	BALL MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0089 Component CCN: 15-T089		
		Ti +1 a V/// / /	Cubaravi dar	DDC

			Title	· XVIII	Subprovi der - I RF	PPS	
		Cos	:ts		IKF		
	Cost Center Description	Cost	Cost				
	cost center bescription	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00	1			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0				60.00
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	0	0				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68.00	06800 SPEECH PATHOLOGY	0	0				68. 00
68. 01	06801 AUDI OLOGY	0	0				68. 01
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	403				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	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	•			90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	0	0	1			90. 01
90. 02	09002 PAIN CLINIC	0	0	1			90. 02
90. 03	09003 ONCOLOGY CLINIC	0	0	1			90. 03
91. 00	09100 EMERGENCY	0	0				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
92. 01	09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0				92. 01
05.05	OTHER REIMBURSABLE COST CENTERS			1			05 00
95.00	09500 AMBULANCE SERVICES	0	, = =				95. 00
200.00		0	403				200. 00
201.00		0					201. 00
202 20	Only Charges		400				202 00
202.00	Net Charges (line 200 - line 201)	0	403	l			202. 00

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	7, 302, 158	0	7, 302, 15			
31.00 INTENSIVE CARE UNIT	1, 136, 572		1, 136, 57	2 8, 360	135. 95	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	354, 977		354, 97	7 2, 923	121. 44	35. 00
40. 00 SUBPROVI DER - I PF	0	0		0 0	0.00	40.00
41. 00 SUBPROVI DER - I RF	456, 222	0	456, 22	2 4, 846	94. 14	41.00
43. 00 NURSERY	188, 039		188, 03	9 2, 228	84. 40	43.00
200.00 Total (lines 30 through 199)	9, 437, 968		9, 437, 96	8 89, 282		200. 00
Cost Center Description	I npati ent	I npati ent		_		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 497					30.00
31.00 INTENSIVE CARE UNIT	380	51, 661				31.00
32. 00 CORONARY CARE UNIT	0	0)			32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	370	44, 933				35. 00
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	107	10, 073	8			41.00
43. 00 NURSERY	1, 539	129, 892	2			43.00
200.00 Total (lines 30 through 199)	4, 893	493, 650)			200. 00

Health Financial Systems	BALL MEMORIAL HOSPI	'I TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLAR	SERVICE CAPITAL COSTS Pro		Peri od:	Worksheet D

From 01/01/2023 To 12/31/2023 Part II Date/Time Prepared: 5/24/2024 9: 21 am Title XIX Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent (from Wkst. C, to Charges (column 3 x Related Cost Program (from Wkst. B. column 4) Part I, col. (col. 1 ÷ col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 1, 458, 982 50.00 05000 OPERATING ROOM 0.006074 1, 382, 677 50.00 240, 203, 943 8.398 51.00 05100 RECOVERY ROOM 326, 446 33, 076, 241 0.009870 176, 400 1, 741 51.00 05200 DELIVERY ROOM & LABOR ROOM 467, 104 0.015818 536, 916 52.00 29, 529, 990 8, 493 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 368, 683 270, 311, 674 0.008763 1, 224, 751 10, 732 54.00 54.00 78, 185 05700 CT SCAN 57, 392, 281 0.001362 57.00 622, 819 848 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 572, 677 128, 463, 185 0.004458 323, 292 1.441 59.00 06000 LABORATORY 0.005775 1, 799, 469 60 00 708, 094 122, 622, 894 10 392 60 00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 3,750 7, 647, 350 0.000490 154, 038 75 63.00 7, 570 65.00 06500 RESPIRATORY THERAPY 208, 134 32, 576, 084 0.006389 1, 184, 921 65.00 06501 SLEEP LAB 0.000589 5 308 9, 008, 836 65 01 65 01 Ω 66.00 06600 PHYSI CAL THERAPY 684, 097 24, 990, 967 0.027374 127, 833 3, 499 66.00 06700 OCCUPATIONAL THERAPY 7, 595, 158 67.00 93, 585 0.012322 78, 883 972 67.00 06800 SPEECH PATHOLOGY 24, 697 68 00 4, 460, 826 0.005536 118, 764 657 68 00 68.01 06801 AUDI OLOGY 0.000000 0 68.01 06900 ELECTROCARDI OLOGY 609, 336 49, 283, 823 0.012364 495, 429 6, 125 69.00 69.00 1, 822 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 314, 565 99, 845, 529 0.003151 578, 266 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 265, 200 155, 942, 276 0.001701 453 72 00 266, 217 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 349, 782 409, 017, 958 0.000855 3, 487, 519 2, 982 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 222, 584 21, 891, 431 0.010168 0 73.01 74.00 07400 RENAL DIALYSIS 109, 596 4, 331, 344 0.025303 154, 906 3, 920 74.00 03160 CARDI OPULMONARY 0.000000 76.00 76.00 0 76.97 07697 CARDIAC REHABILITATION 7, 995 7, 221, 569 0.001107 20, 209 22 76.97 30, 494 07698 HYPERBARI C OXYGEN THERAPY 0.001261 0 76. 98 76.98 24, 186, 899 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0.000000 0 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0.000000 741, 027 09001 SUBSTANCE ABUSE CLINIC 234, 756 0.316798 90.01 90.01 0 0 09002 PAIN CLINIC 90 02 816, 730 3, 406, 435 0.239761 0 Λ 90 02 09003 ONCOLOGY CLINIC 294, 893 52, 011, 215 0.005670 49, 487 90.03 90.03 281 91.00 09100 EMERGENCY 1, 380, 125 295, 798, 266 0.004666 2, 216, 229 10, 341 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 078, 160 33, 276 92.00 92.00 65, 390, 835 0.016488 549 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 169, 266 8, 693, 279 0.019471 0 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 200.00 12, 883, 224 2, 165, 641, 315 15, 032, 301 81, 313 200. 00 Total (lines 50 through 199)

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	BALL MEMORIA		^N: 15 0000 [In Lie Period:	w of Form CMS-: Worksheet D	2552-10
APPORTIONMENT OF IMPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH CUS	is Provider Co	F	From 01/01/2023 o 12/31/2023	Part III	
		Ti tl	e XIX	Hospi tal	PPS	ı allı
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
·	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments 1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	Ō				
32. 00 03200 CORONARY CARE UNIT	0	0	(0	0	32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	(0	0	35. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	(0	0	
41. 00 04100 SUBPROVI DER - I RF	0	0	(0	0	
43. 00 04300 NURSERY	0	0	(0	0	
200.00 Total (lines 30 through 199) Cost Center Description	Swi ng-Bed	Total Costs	Total Dationt	Per Diem (col.	Inpati ent	200. 00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Jayo	0 1 0011 0)	l og. a bajo	
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			70.00		0 407	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	0				
32. 00 03200 CORONARY CARE UNIT		0	8, 300		•	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0	2, 923		l	
40. 00 04000 SUBPROVI DER - PF	0	0	2, 726		l	
41. 00 04100 SUBPROVI DER - RF	0	Ö	4, 846			
43. 00 04300 NURSERY		0			1, 539	43.00
200.00 Total (lines 30 through 199)		0	89, 282	2	4, 893	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
40. 00 04000 SUBPROVI DER - PF	0					40.00
41. 00 04100 SUBPROVI DER - 1 RF 43. 00 04300 NURSERY	0					41. 00 43. 00
	()					1 4.5 OO
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	BALL MEMORIAL HOSPITAL			u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0089	Peri od:	Worksheet D

From 01/01/2023 | Part IV To 12/31/2023 | Date/Time Prepared: THROUGH COSTS 5/24/2024 9: 21 am Title XIX Hospi tal PPS Cost Center Description Non Physician Nursi ng Allied Health Allied Health Nursi ng Anestheti st Post-Stepdown Program Program Cost Post-Stepdown Adi ustments Adjustments 1.00 3. 00 2A 2.00 ЗА ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 00000000000000000000000000000000 0 05100 RECOVERY ROOM 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 05700 CT SCAN 0 57.00 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 60.00 06000 LABORATORY 0 0 60.00 Oi 06001 BLOOD LABORATORY 0 60.01 60.01 Λ 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 65.00 0 0 65.01 06501 SLEEP LAB 65.01 0 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0 68.00 0 06801 AUDI OLOGY 0 68.01 68 01 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 333, 894 73 00 73 00 0 73.01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 03160 CARDI OPULMONARY 0 76.00 0 76.00 0 07697 CARDIAC REHABILITATION 0 0 76.97 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 0 09001 SUBSTANCE ABUSE CLINIC 90.01 0 0 0 0 0 0 90.01 0 90. 02 09002 PAIN CLINIC 0 90. 02 0 09003 ONCOLOGY CLINIC 0 90.03 0 0 0 90.03 09100 EMERGENCY 0 91.00 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 0 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES

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0

333, 894 200. 00

200.00

Health Financial Systems	BALL MEMORIAL H	In Li€	eu of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0089	Peri od:	Worksheet D

From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: THROUGH COSTS 5/24/2024 9: 21 am Title XIX Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 240, 203, 943 0.000000 50.00 00000000000000000000000000000 51.00 05100 RECOVERY ROOM 0 0 33, 076, 241 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 29, 529, 990 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 270, 311, 674 0.000000 54 00 0 57.00 05700 CT SCAN 0 57, 392, 281 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 128, 463, 185 0.000000 59.00 06000 LABORATORY 0 60.00 0 122, 622, 894 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 7, 647, 350 0.000000 63.00 06500 RESPIRATORY THERAPY 32, 576, 084 0 000000 65 00 65 00 65.01 06501 SLEEP LAB 9, 008, 836 0.000000 65.01 06600 PHYSI CAL THERAPY 24, 990, 967 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 7, 595, 158 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY Ω 4, 460, 826 0.000000 68 00 68.01 06801 AUDI OLOGY 0 0.000000 68.01 06900 ELECTROCARDI OLOGY 49, 283, 823 0.000000 69.00 69.00 99, 845, 529 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENT O 155, 942, 276 0.000000 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 333, 894 333, 894 409, 017, 958 0.000816 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 21, 891, 431 0.000000 73.01 0 73.01 07400 RENAL DIALYSIS 74.00 0 4, 331, 344 0.000000 74.00 0 03160 CARDI OPULMONARY 0 0.000000 76.00 C 76 00 76. 97 07697 CARDIAC REHABILITATION 0 0 7, 221, 569 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 24, 186, 899 0.000000 76. 98 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 77.00 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0.000000 90.00 90.01 09001 SUBSTANCE ABUSE CLINIC 0 741, 027 0.000000 90 01 C 0 90.02 09002 PAIN CLINIC C 3, 406, 435 0.000000 90.02 0 09003 ONCOLOGY CLINIC 90. 03 0 0 52, 011, 215 0.000000 90.03 09100 EMERGENCY 91.00 0 295, 798, 266 0.000000 91.00 C 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 65, 390, 835 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 8, 693, 279 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00

0

333, 894

333, 894 2, 165, 641, 315

200.00

200.00

Health Financial Systems	BALL MEMORIAL H	BALL MEMORIAL HOSPITAL		Lieu of Form CMS-2552-10
ADDODTI ONIMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER DASS	Provider CCN: 15-0080	Peri od:	Workshoot D

Part IV From 01/01/2023 THROUGH COSTS 12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through to Charges Pass-Through Charges Charges (col. 6 ÷ col Costs (col. Costs (col. x col. 12) 13.00 x col. 10) 7) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 1, 382, 677 0 0 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 176, 400 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 536, 916 0 52.00 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 1, 224, 751 0 54.00 0 54.00 0 05700 CT SCAN 0.000000 57.00 57.00 622, 819 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 323, 292 0 0 59.00 0 06000 LABORATORY 0.000000 1, 799, 469 60 00 0 60 00 0 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0.000000 154, 038 0 63.00 06500 RESPIRATORY THERAPY 0 65.00 0.000000 1, 184, 921 0 65.00 0 06501 SLEEP LAB 0.000000 65 01 0 65 01 66.00 06600 PHYSI CAL THERAPY 0.000000 127, 833 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 78, 883 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 0.000000 118, 764 0 68 00 0 68.01 06801 AUDI OLOGY 0.000000 0 68.01 69.00 06900 ELECTROCARDI OLOGY 0.000000 495, 429 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 578, 266 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0.000000 O 72 00 266, 217 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000816 3, 487, 519 2,846 0 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 0.000000 0 73.01 74.00 07400 RENAL DIALYSIS 0.000000 154, 906 0 0 74.00 03160 CARDI OPULMONARY 0.000000 0 76.00 76.00 0 76.97 07697 CARDIAC REHABILITATION 0.000000 20, 209 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 76. 98 76.98 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0.000000 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 90 00 0.000000 0 90.01 09001 SUBSTANCE ABUSE CLINIC 0.000000 0 0 90.01 0 0 09002 PAIN CLINIC 90.02 90 02 0.000000 0 90.03 09003 ONCOLOGY CLINIC 0.000000 49, 487 0 90.03 0 0 91.00 09100 EMERGENCY 0.000000 2, 216, 229 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 33, 276 0 92.00 92.00 0.000000 0 0 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 0 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00

15, 032, 301

2.846

0

0 200.00

200.00

Total (lines 50 through 199)

Heal th	Financial Systems	BALL MEMORIA	AL HOSPITAL		In Lie	u of Form CMS	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0089	Peri od:	Worksheet D	
					From 01/01/2023	Part V	
					To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
			T: +1	e XIX	Hocni tal	PPS	ı allı
			11 (1		Hospi tal		
	0 1 0 1 0 1 1		DDC D ' 1	Charges	0 1	Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 107696	1	1, 278, 24		0	50.00
51.00	05100 RECOVERY ROOM	0. 153066	C	226, 80	0 0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 264932	: C	115, 59	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 103292	el c	3, 107, 02	25 0	0	54. 00
57.00	05700 CT SCAN	0. 062021		539, 28	37 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	•		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 064844	1	1		0	59. 00
60.00	06000 LABORATORY	0. 186153	1			0	60.00
60. 00	06001 BL00D LABORATORY	0. 000000	1		0 0	0	1
	I I		1	1			60. 01
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 232460		0,00		0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0. 233857	ł .	1,		0	65. 00
65. 01	06501 SLEEP LAB	0. 117707		1,		0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0. 410455	1	1,		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 241763		1 ., -		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 229370		11, 24	5 0	0	68. 00
68. 01	06801 AUDI OLOGY	0. 000000) C)	0 0	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	0. 107540	0	279, 48	35 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 222866	C	423, 19	0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 127386	ol c	579, 58	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 181259	ol c	3, 105, 73	5 0	0	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	1. 282899	ol c		0 0	0	73. 01
74. 00	07400 RENAL DIALYSIS	0. 488773	•	5, 10	0	0	74. 00
76. 00	03160 CARDI OPULMONARY	0. 000000	•	1	0 0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 231130		1		Ö	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 108906	l	1		0	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			0 0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	1	l	0 0	0	78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000	'	<u>′I</u>	0 0	0	70.00
90. 00	09000 CLINIC	0. 000000) c	VI.	0 0	0	90.00
90. 00	09001 SUBSTANCE ABUSE CLINIC	1. 636075		l		0	90.00
			I	1 .,		_	
90. 02	09002 PAIN CLINIC	0. 683359	1	25, 41		0	90. 02
90. 03	09003 ONCOLOGY CLINIC	0. 124579				0	90. 03
91. 00	09100 EMERGENCY	0. 093507		1 -,,		0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 198447	1			0	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 244414	- C	57, 86	5 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0. 000000		1	0		95. 00
200.00	Subtotal (see instructions)		C	20, 276, 44	0 0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		C	20, 276, 44	0 0	0	202. 00
					·		

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0089 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 9:21 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 137, 662 0 50.00 51.00 05100 RECOVERY ROOM 34, 715 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 30 625 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 320, 931 0 54.00 57. 00 05700 CT SCAN 33, 447 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 13, 307 59.00 60.00 06000 LABORATORY 221, 438 0 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 0 72 303 63 00 63 00 65.00 06500 RESPIRATORY THERAPY 16,051 0 65.00 65.01 06501 SLEEP LAB 12,675 0 65.01 06600 PHYSI CAL THERAPY 128, 438 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 1, 122 67.00 68.00 06800 SPEECH PATHOLOGY 2,579 0 68.00 06801 AUDI OLOGY 68.01 68.01 69.00 06900 ELECTROCARDI OLOGY 30, 056 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 94.315 0 71.00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73,831 0 72.00 07300 DRUGS CHARGED TO PATIENTS 562, 942 0 73.00 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 0 73. 01 73.01 07400 RENAL DIALYSIS 0 74.00 2.497 74 00 76.00 03160 CARDI OPULMONARY 0 76.00 07697 CARDIAC REHABILITATION 76. 97 1, 121 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 45, 972 0 76. 98 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 90.00 0 90. 01 09001 SUBSTANCE ABUSE CLINIC 2,089 0 90.01

17, 364

143, 717

491, 305

294, 918

2, 799, 563

2, 799, 563

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90.02

90.03

91.00

92.00

92.01

95.00

200.00

201.00

202.00

09002 PAIN CLINIC

09100 EMERGENCY

09003 ONCOLOGY CLINIC

09500 AMBULANCE SERVICES

Only Charges

09200 OBSERVATION BEDS (NON-DISTINCT PART)

09201 OBSERVATION BEDS (DISTINCT PART)

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

OTHER REIMBURSABLE COST CENTERS

90. 02

90.03

91.00

92.00

92.01

95.00

200.00

201.00

202.00

Component CCN: 15-T089

Subprovi der -Title XIX

			Titl	e XIX	Subprovi der -	Cost	
				Charges	I RF	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11131.)	
		Part I, col. 9	,	Subject To	Subject To		
		lart i, coi. 7		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATI NG ROOM	0. 107696	0	C		0	50.00
51.00	05100 RECOVERY ROOM	0. 153066	0	(0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 264932	0	(0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 103292	0	(0	0	54.00
57.00	05700 CT SCAN	0. 062021	0	(0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	(0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 064844	0	(0	0	59. 00
60.00	06000 LABORATORY	0. 186153	0	(0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	C	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 232460	0	C	0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0. 233857	0	C	0	0	65. 00
65. 01	06501 SLEEP LAB	0. 117707	0	C	0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0. 410455	0	153, 687	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 241763	0	C	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 229370	0	C	0	0	68. 00
68. 01	06801 AUDI OLOGY	0. 000000	0	C	0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	0. 107540	0	C	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 222866	0	C	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 127386	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 181259	0	C	0	0	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	1. 282899	0	C	0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 488773	0	C	0	0	74.00
76.00	03160 CARDI OPULMONARY	0. 000000	0	C	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 231130	0	C	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 108906	0	(0	0	76. 98
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	C	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000				0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	1. 636075	0	(0	0	90. 01
90. 02	09002 PAIN CLINIC	0. 683359	0	(0	0	90. 02
90. 03	09003 ONCOLOGY CLINIC	0. 124579	0	(0	0	90. 03
91.00	09100 EMERGENCY	0. 093507	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 198447	0	(0	0	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 244414	0	(0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS	1					
95. 00	09500 AMBULANCE SERVICES	0. 000000		(95. 00
200.00			0	153, 687		0	200.00
201.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				0		201. 00
202 22	Only Charges		_	150 (0	,	_	202 00
202.00	Net Charges (line 200 - line 201)	1	0	153, 687	0	0	202. 00

Health Financial Systems	BALL MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0089 Component CCN: 15-T089	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/24/2024 9:21 am

		Title XIX	Subprovi der - I RF	Cost
	Costs		IKF	
Cost Center Description	Cost	Cost		
		Reimbursed		
		ervices Not Subject To		
		ed. & Coins.		
		see inst.)		
	6.00	7. 00		
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0	0		50.00
51. 00 05100 RECOVERY ROOM	0	0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN		0		54. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (M	31)	0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	,	ol		59.00
60. 00 06000 LABORATORY	o	ol		60.00
60. 01 06001 BLOOD LABORATORY	o	o		60. 01
63.00 06300 BLOOD STORING, PROCESSING, &	TRANS. 0	0		63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		65. 00
65. 01 06501 SLEEP LAB	0	O		65. 01
66. 00 06600 PHYSI CAL THERAPY	63, 082	0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		67. 00 68. 00
68. 01 06800 SPEECH PATHOLOGY		0		68. 01
69. 00 06900 ELECTROCARDI OLOGY		0		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PA	ATI ENTS 0	ol		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	O	O		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	o		73. 00
73.01 07301 HOSPITAL BASED RETAIL PHARMAC	ES 0	0		73. 01
74.00 07400 RENAL DIALYSIS	0	0		74. 00
76. 00 03160 CARDI OPULMONARY	0	0		76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION		0		76. 98 77. 00
78. 00 07700 ALLOGENET C HSCT ACCORSTTON 78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0		78.00
OUTPATIENT SERVICE COST CENTERS		<u> </u>		70.00
90. 00 09000 CLI NI C	0	0		90.00
90.01 09001 SUBSTANCE ABUSE CLINIC	0	O		90. 01
90. 02 09002 PAIN CLINIC	0	0		90. 02
90. 03 09003 0NCOLOGY CLINIC	0	O		90. 03
91. 00 09100 EMERGENCY	0	0		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINC 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PA	- 1	0		92. 00
OTHER REIMBURSABLE COST CENTERS	(1)	U _I		92.01
95. 00 09500 AMBULANCE SERVICES	0			95. 00
200.00 Subtotal (see instructions)	63, 082	О		200. 00
201.00 Less PBP Clinic Lab. Services				201. 00
Only Charges				
202.00 Net Charges (line 200 - line	201) 63, 082	0		202. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	Peri od: From 01/01/2023	Worksheet D-1
		To 12/31/2023	Date/Time Prepared: 5/24/2024 9:21 am
	Title XVIII	Hospi tal	PPS

Note Cost Center Description 100				10 12/31/2023	5/24/2024 9: 2	
PART ALL PROVIDIR COMPONINTS			Title XVIII	Hospi tal		
PART - ALL PROVIDER COMPONENTS		Cost Center Description				
Inpatient days (Including private room days, and swing-bed days, excluding newborm)		DADT I ALL DROW DED COMPONENTS			1. 00	
Inpatient days (including private room days, excluding swing-bed mays, excluding newborn days) 70,925 2.0						1
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7.00 private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. Some i-private room days (excluding swing-bed and observation bed days). Through December 31 of the cost of the cost and in the cost of	2. 00					
	3.00			ivate room days,		3.00
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10.00 Nursery days (title V or XIX only) 0 16.00	14. 00				0	14. 00
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Title XVIII Program		Financial Systems ATION OF INPATIENT OPERATING COST	BALL MEMORIAL	Provi der CC	CN: 15-0089	Peri od: From 01/01/2023	Worksheet D-1	
Total						To 12/31/2023	Date/Time Pre	
		Cost Center Description	Total	_				
MESSERY CITED V 8 XIX only 0			Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
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64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 61 Aljusted general inpatient routine service cost per diem (line 70 * line 2) 62 Total Program routine service cost (line 9 x line 71) 63 Total Program general inpatient routine service costs (line 72 + line 73) 64 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 65 Total Program routine service cost (line 74 minus line 77) 66 Total Program routine service costs (line 9 x line 70) 67 Total Program routine service costs (line 9 x line 70) 68 Total Program routine service costs (from provider records) 69 Total Program routine service costs (from provider records) 60 Total Program inpatient routine service costs (see instructions) 60 Total Program inpatient routine service (see instructions) 61 Total Program inpatient poerating costs (see instructions) 62 Total Program inpatient poerating costs (sum of lines 83 through 85) 63 Total Program inpatient operating costs (sum of lines 83 through 85)	53.00		ent (see Enstruc	ctions)			0	63. 00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (itite XVIII only): 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 + line 2) Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 78.00 Program capital-related costs (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost from service cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine services (see instructions) 94.00 Program inpatient acciliary services (see instructions) 10 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ing period (See	0	64. 00
instructions) (title XVIII only) 60.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 71.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost per diem limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 80.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 80.00 Reasonable inpatient routine service costs (see instructions) 80.00 Utilization review - physician compensation (see instructions) 80.00 Total Program inpatient operating costs (sum of lines 83 through 85) 80.00 Total Program inpatient operating costs (sum of lines 83 through 85) 80.00 Total Program inpatient operating costs (sum of lines 83 through 85)	65 OO		ts after Decembe	er 31 of the c	ost reportin	a period (See	0	65. 00
CAH, see instructions 7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 7.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 7.20 Program routine service cost (line 9 x line 71) 8.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 8.10 Total Program general inpatient routine service costs (line 72 + line 73) 8.10 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 8.10 Per diem capital -related costs (line 75 + line 2) 9.10 Program capital -related costs (line 9 x line 76) 10 Inpatient routine service cost (line 74 minus line 77) 9.10 Aggregate charges to beneficiaries for excess costs (from provider records) 10 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 11 Inpatient routine service cost limitation (line 9 x line 81) 12 Reasonable inpatient routine service cost (see instructions) 13 Program inpatient ancillary services (see instructions) 14 Program inpatient ancillary services (see instructions) 15 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		instructions)(title XVIII only)			·			
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 70.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 79.10 Inpatient routine service cost (see instructions) 79.10 Program inpatient routine service costs (see instructions) 79.11 Program inpatient ancillary services (see instructions) 79.12 Program inpatient ancillary services (see instructions) 79.13 Program inpatient operating costs (sum of lines 83 through 85) 70.14 Program inpatient operating costs (sum of lines 83 through 85) 70.15 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	66. 00	•	ne costs (line 6	o4 plus line 6	5)(title XVI	II only); for	0	66. 00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 80 Inpatient routine service cost (line 74 minus line 77) 81 Aggregate charges to beneficiaries for excess costs (from provider records) 82 Ol Inpatient routine service cost per diem limitation 83 Ol Inpatient routine service cost per diem limitation 84 Ol Inpatient routine service cost (see instructions) 85 Ol Utilization review - physician compensation (see instructions) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost r	eporting period	0	67. 00
69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) 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, column 26, line 45) Per diem capital-related costs (line 75 + line 2) Program capital-related costs (line 78 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost per diem limitation Inpatient routine service cost per diem limitation Inpatient routine service cost per diem limitation Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Total Program inpatient ancillary services (see instructions) Program inpatient per physician compensation (see instructions) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	69. 00	· ·	routine costs (I	ine 67 + line	68)		0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	70.00					`	T	70.00
Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) 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, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 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) Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST)		70.00
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, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) 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) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	72. 00	Program routine service cost (line 9 x line	71)					72. 00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		3 3 1	9	•	,			73.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		o o .	,			Part II, column		74. 00 75. 00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	7/ 00		2)					7/ 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								76. 00 77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						nue lino 70)		79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		· ·		ot iiiii täti on	(IIIIE /8 MI	nus iine 79)		80.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	32. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				5)				83. 00 84. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				ıs)				85.00
		Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
10,472	87. NO						10 472	 87 NN
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,239.17 89.00 Observation bed cost (line 87 x line 88) (see instructions) 1,2976,588	88. 00			line 2)			1, 239. 17	88. 00

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 9: 2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	7, 302, 158	87, 887, 812	0. 08308	5 12, 976, 588	1, 078, 160	90.00
91.00 Nursing Program cost	0	87, 887, 812	0.00000	0 12, 976, 588	0	91.00
92.00 Allied health cost	0	87, 887, 812	0.00000	0 12, 976, 588	0	92.00
93.00 All other Medical Education	0	87, 887, 812	0. 00000	0 12, 976, 588	0	93. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T089	To 12/31/2023	Date/Time Prepared: 5/24/2024 9:21 am
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 846	1. 00
2.00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day			4, 846	
3.00	do not complete this line.	(S). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 846	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room)	om days) after December 3	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember e	or or the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n davs) after December 31	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember 31	or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 917	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	oly (i polydina privato ro	om days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (frictually private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar ye	•	, i	0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (excluding swing-bed c	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		2.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	tne cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
19. 00	reporting period	through December 21 of	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		4, 850, 683	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)	0.1			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
25 00	7 x line 19))1 -6 thtt!		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 850, 683	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi - pri vate room charges (excluding swing-bed charges)	lino 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3)	- TTHE 28)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mir		i ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	4, 850, 683	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 000. 97	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 918, 859	39. 00
40.00	Medically necessary private room cost applicable to the Program	•		0 1, 918, 859	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ 11110 40)	I	1, 918, 859	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	BALL MEMORIAL		CCN: 15-0089	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T089	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			Ti tl	e XVIII	Subprovi der -	5/24/2024 9: 2 PPS	21 am
	Cost Center Description	Total	Total	Average Pe	IRF er Program Days	Program Cost	
	, , , , , , , , , , , , , , , , , , , ,	Inpatient Cost	npatient Day	sDiem (col. col. 2)	1 ÷	(col. 3 x col. 4)	
2. 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00 0 0	4. 00 . 00	5. 00	42.0
	Intensive Care Type Inpatient Hospital Units]
3. 00 4. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0			. 00 C	1	
	BURN INTENSIVE CARE UNIT			"	. 00		45. 0
	SURGICAL INTENSIVE CARE UNIT						46. (
7. 00	NEONATAL INTENSIVE CARE UNIT	0		0 0	. 00	0	47. (
	Cost Center Description					1.00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1, 532, 113	48.0
8. 01 9. 00	Program inpatient cellular therapy acquisition total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				O, column 1)	0 3, 450, 972	1
0. 00	Pass through costs applicable to Program inp	atient routine s	ervices (fro	m Wkst. D, s	um of Parts I and	180, 466	50.0
1. 00	III) Pass through costs applicable to Program inp and IV)	atient ancillary	services (f	rom Wkst. D,	sum of Parts II	78, 266	51. (
2. 00	Total Program excludable cost (sum of lines	50 and 51)				258, 732	52. (
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital rel	ated, non-ph	ysician anes	thetist, and	3, 192, 240	
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					Ι ο	54.
5. 00	Target amount per discharge					0.00	
5. 01	Permanent adjustment amount per discharge					•	55.
5. 02	Adjustment amount per discharge (contractor					1	55.
6. 00 7. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		act amount (lino 56 minu	c lino 52)	0 0	
8. 00	Bonus payment (see instructions)	ing cost and tai	get amount (Title 50 illitiu	s i i ile 53)		
9. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting perio	d endi ng 1996,	0.00	59.
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year	cost report,	updated by the	0.00	60.
1. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by	which operat	ing costs (line	0	61.
	Relief payment (see instructions)					0	
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of th	e cost repor	ting period (See	0	64.
5. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)					0	
6. 00 7. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions Title V or XIX swing-bed NF inpatient routin	·	·		3,	0	
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	-				0	
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI					0	69.
0. 00	Skilled nursing facility/other nursing facil				7)		70.
	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71.
	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 v l	ine 25)			72.
3. 00 4. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						74.
5. 00	Capital -related cost allocated to inpatient 26, line 45)	•		•	Part II, column		75.
6. 00	Per diem capital-related costs (line 75 ÷ li						76.
	Program capital -related costs (line 9 x line						77.
8. 00 9. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider recor	ds)			78. 79.
0. 00	Total Program routine service costs for comp			*.	inus line 79)		80.
1. 00	Inpatient routine service cost per diem limi	tati on			•		81.
2.00	Inpatient routine service cost limitation (I		`				82.
1 1/1							

83.00

84. 00

85.00

86.00

0 87.00 0.00 88.00

84.00

85.00

86.00

83.00 Reasonable inpatient routine service costs (see instructions)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
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	
				,	(col. 3 x col.	
				11110 07)	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	456, 222	4, 850, 683	0. 09405	3 0	0	90. 00
91.00 Nursing Program cost	0	4, 850, 683	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 850, 683	0.00000	ol o	0	92.00
93.00 All other Medical Education	o	4, 850, 683			0	93. 00
	1			1		

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/24/2024 9:21 am
	Title XIX	Hospi tal	PPS

				5/24/2024 9: 2	1 am
		Title XIX	Hospi tal	PPS	
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s. excludina newborn)		70, 925	1.00
2.00	Inpatient days (including private room days, excluding swing-			70, 925	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.		•	 -	
4.00	Semi-private room days (excluding swing-bed and observation be			60, 453	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
,	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December	31 OF the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
7.00	reporting period	adys) in odgi becember	or or the cost	١	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7		 -	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 497	9. 00
	newborn days) (see instructions)			 	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		dolli days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
	through December 31 of the cost reporting period	· ····y (······ ·······················		- I	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye			 	
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
15. 00	Total nursery days (title V or XIX only)			2, 228	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			1, 539	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
.,,	reporting period	oo tiii dagii badambal di d		0.00	''''
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of t	ho cost	0. 00	20.00
20.00	reporting period	s arter becember 31 or t	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	5)		87, 887, 812	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)			 -	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24.00	X line 18)	- 21 of the cost reservi	na noried (line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng perrou (Trie	U	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		, , , , ,	· [
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		87, 887, 812	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and alexander to the first			00.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Pri vate room charges (excluding swing-bed charges)			0	29. 00 30. 00
31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	F 11116 20)		0.00000	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		<i>'</i>	0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	87, 887, 812	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		T	1 220 17	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 239. 17 3, 094, 207	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		3, 094, 207	40.00
	Total Program general inpatient routine service cost (line 39			3, 094, 207	1
		•	'		•

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN:		Period: From 01/01/2023	u of Form CMS-2 Worksheet D-1	
					To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
			Title		Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costlr	Total / npatient Days Di	Average Per em (col. 1 col. 2)	Program Days ÷	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 1, 319, 701	2. 00	3. 00 592. 3	4. 00 3 1, 539	5. 00 911, 596	42. 00
42.00	Intensive Care Type Inpatient Hospital Unit		2, 220	372. 3	3 1, 539	911, 390	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	18, 573, 713 0	8, 360 0	2, 221. 7 0. 0		844, 261 0	43. 00 44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	4, 809, 690	2, 923	1, 645. 4	6 370	608, 820	47. 00
	·					1. 00	
	Program inpatient ancillary service cost (V Program inpatient cellular therapy acquisi			l line 10	column 1)	2, 403, 253 0	
	Total Program inpatient costs (sum of lines				COI dillii 1)	7, 862, 137	
	PASS THROUGH COST ADJUSTMENTS					===	
50. 00	Pass through costs applicable to Program in	npatient routine se	ervices (from W	KST. D, SUM	of Parts I and	483, 577	50.00
51. 00	Pass through costs applicable to Program in	npatient ancillary	services (from	Wkst. D, s	um of Parts II	84, 159	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	s 50 and 51)				567, 736	52.00
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	uding capital rela	ated, non-physi	cian anesth	etist, and	7, 294, 401	
54. 00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
	Target amount (line 54 x sum of lines 55, 5					0	l l
	Difference between adjusted inpatient opera	ating cost and targ	get amount (lin	e 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost report	ina period	endi na 1996.	0 0. 00	
60. 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54 market basket)	t)				0.00	
61. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	esser of 50% of the	amount by whi	ch operatin	g costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive pay	yment (see instruc	tions)			0	63. 00
64 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	osts through Decemb	per 31 of the c	nst renorti	ng period (See	0	64. 00
01.00	instructions)(title XVIII only)	osts thi odgir becom		ost reporti	ing period (see	Ü	01.00
65. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts after December	31 of the cos	t reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rout	tine costs (line 64	l plus line 65)	(title XVII	l only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through [ecember 31 of	the cost re	norting period	0	67.00
	(line 12 x line 19)	•					
68. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after Dec	cember 31 of th	e cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci						70.00
71. 00	Adjusted general inpatient routine service	cost per diem (li		,			71.00
	Program routine service cost (line 9 x line Medically necessary private room cost appli		lino 14 v lino	25)			72. 00 73. 00
	Total Program general inpatient routine ser			33)			74.00
75. 00	Capital-related cost allocated to inpatient	t routine service o	costs (from Wor	ksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
	Program capital -related costs (line 9 x lin						77. 00
	Inpatient routine service cost (line 74 mir		widor records)				78.00
	Aggregate charges to beneficiaries for exce Total Program routine service costs for cor			line 78 min	us line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem lir	ni tati on			,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs	* . * .	1				82. 00 83. 00
84. 00	Program inpatient ancillary services (see i	,					84.00
85. 00	Utilization review - physician compensation	n (see instructions					85. 00
86. 00	Total Program inpatient operating costs (support IV - COMPUTATION OF OBSERVATION BED PA		ough 85)				86. 00
87. 00	Total observation bed days (see instruction					10, 472	87. 00
67.00							

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 9: 2	oared: 1 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	7, 302, 158	87, 887, 812	0. 08308	5 12, 976, 588	1, 078, 160	90.00
91.00 Nursing Program cost	0	87, 887, 812	0.00000	12, 976, 588	0	91.00
92.00 Allied health cost	0	87, 887, 812	0.00000	12, 976, 588	0	92.00
93.00 All other Medical Education	0	87, 887, 812	0.00000	12, 976, 588	0	93. 00

Health Financial Systems	BALL MEMORIAL H	IOSPI TAL		In Lieu of Form CMS-2552-10
INDATIENT ANGLILADY SERVICE COST ADDODTIONMENT		Drovi don CCN, 1E 0000	Pori od:	Workshoot D 2

Heal th Finar	ncial Systems BALL MEMORIAL	HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
I NPATI ENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0089	Peri od:	Worksheet D-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
		Ti +l c	e XVIII	Hospi tal	PPS	ı allı
	Cost Center Description	11116	Ratio of Cos		Inpati ent	
	Cost Center Description		To Charges	Program	Program Costs	
			10 charges	Charges	(col. 1 x col.	
				onal goo	2)	
			1.00	2. 00	3. 00	
I NPAT	FLENT ROUTINE SERVICE COST CENTERS				•	
30. 00 03000	ADULTS & PEDIATRICS			64, 746, 106		30. 00
31.00 03100	INTENSIVE CARE UNIT			17, 946, 126		31.00
32.00 03200	CORONARY CARE UNIT			0		32. 00
35. 00 02060	NEONATAL INTENSIVE CARE UNIT			0		35. 00
	SUBPROVI DER - I PF			0		40. 00
	SUBPROVI DER - I RF			0		41. 00
	D NURSERY					43. 00
	LARY SERVICE COST CENTERS		T	T	T	
	OPERATING ROOM		0. 1076	· · · · · ·		
	RECOVERY ROOM		0. 1530			1
	DELIVERY ROOM & LABOR ROOM		0. 2649			
	RADI OLOGY-DI AGNOSTI C		0. 1032			
	CT SCAN		0. 0620			
58.00 05800	MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	58. 00
	CARDI AC CATHETERI ZATI ON		0.0648	· · · · ·		
	LABORATORY		0. 1861!			
	BLOOD LABORATORY		0.00000			
	DBLOOD STORING, PROCESSING, & TRANS. RESPIRATORY THERAPY		0. 2324			1
	SLEEP LAB		0. 2338! 0. 11770		1, 791, 738 720	
1	PHYSI CAL THERAPY		0. 11770			1
	OCCUPATIONAL THERAPY		0. 4104	· · · · ·		1
1	SPEECH PATHOLOGY		0. 2293	· ·		1
	AUDI OLOGY		0. 00000		170, 320	68. 01
	ELECTROCARDI OLOGY		0. 1075			1
1	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2228			
	IMPL. DEV. CHARGED TO PATIENT		0. 1273			
	DRUGS CHARGED TO PATIENTS		0. 1812		5, 366, 459	
	HOSPITAL BASED RETAIL PHARMACIES		1. 28289		0	1
74.00 07400	RENAL DIALYSIS		0. 4887	73 1, 155, 591	564, 822	74. 00
76. 00 03160	CARDI OPULMONARY		0.0000	00	0	76. 00
76. 97 07697	7 CARDIAC REHABILITATION		0. 2311:	455, 448	105, 268	76. 97
	B HYPERBARI C OXYGEN THERAPY		0. 10890	75, 293	8, 200	76. 98
77. 00 07700	ALLOGENEIC HSCT ACQUISITION		0.0000	00	0	77. 00
	CAR T-CELL IMMUNOTHERAPY		0.0000	00	0	78. 00
	ATIENT SERVICE COST CENTERS					
	CLI NI C		0. 00000		-	
	SUBSTANCE ABUSE CLINIC		1. 6360		0	
	PAIN CLINIC		0. 6833!			
	ONCOLOGY CLINIC		0. 1245	· ·		
	EMERGENCY		0. 09519			
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 1984	· ·		
	OBSERVATION BEDS (DISTINCT PART)		0. 2444	14 31, 622	7, 729	92. 01
	R REIMBURSABLE COST CENTERS AMBULANCE SERVICES		1			05.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			214 254 205	29, 769, 359	95. 00
200.00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		214, 256, 285	27, 107, 359	200.00
202.00	Net charges (line 200 minus line 201)	5 (11116 01)	1	214, 256, 285		201.00
202.00	Thet charges (Title 200 illinas Title 201)		I	214, 230, 203	I	1202.00

Health Financial Systems BALL N	MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	<u>255</u> 2-1
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC	N: 15-0089	Peri od:	Worksheet D-3	
	Component C	CCN: 15-T089	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
	Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
	-	1. 00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30.0
31. 00 03100 NTENSI VE CARE UNI T					31. 00
32. 00 03200 CORONARY CARE UNIT					32. 0
35.00 02060 NEONATAL INTENSIVE CARE UNIT					35. 0
40. 00 04000 SUBPROVI DER - 1 PF					40.0
41. 00 04100 SUBPROVI DER - I RF			5, 070, 429		41. 0
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 10769		8, 442	
51. 00 05100 RECOVERY ROOM		0. 15306		1, 800	
52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC		0. 26493		0	
54. 00 05400 RADI OLOGI - DI AGNOSTI C 57. 00 05700 CT SCAN		0. 10329 0. 06202		20, 604 4, 094	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		4,094	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 06484		102	
60. 00 06000 LABORATORY		0. 18615		60, 491	
60. 01 06001 BLOOD LABORATORY		0.00000		0	1
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 23246		1, 362	63.0
65. 00 06500 RESPI RATORY THERAPY		0. 23385	57, 628	13, 477	65.0
65. 01 06501 SLEEP LAB		0. 11770		0	
66. 00 06600 PHYSI CAL THERAPY		0. 41045		654, 758	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24176		453, 235	
68. 00 06800 SPEECH PATHOLOGY		0. 22937		120, 097	1
68. 01 06801 AUDI OLOGY 69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 10754 0. 2228 <i>6</i>		5, 293 13, 070	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 12738		1, 412	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 18125		138, 636	
73. 01 07301 HOSPI TAL BASED RETAIL PHARMACIES		1. 28289		0	
74. 00 07400 RENAL DI ALYSI S		0. 48877		35, 240	
76. 00 03160 CARDI OPULMONARY		0. 00000		0	1
76.97 07697 CARDIAC REHABILITATION		0. 23113		0	76. 9
76.98 07698 HYPERBARIC OXYGEN THERAPY		0. 10890	06	0	76. 9
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00 0	0	78. 0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINI C		0.00000		0	
90. 01 09001 SUBSTANCE ABUSE CLINIC		1. 63607		0	
90. 02 09002 PAIN CLINIC		0. 68335		0	
90. 03 09003 0NC0L0GY CLI NI C 91. 00 09100 EMERGENCY		0. 12457 0. 09519		0	1
91. UU UU91UU EMERGENCY		0. 09519	-	0	91.0

0. 198447

0. 244414

5, 695, 041

5, 695, 041

0 92.00

95.00

201. 00 202. 00

0 92.01

1, 532, 113 200. 00

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

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

200.00

201.00

202.00

Health Financial Systems BALL MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2023	D 1 /T' D	
			To 12/31/2023	Date/Time Pre 5/24/2024 9:2	
	Ti +I	e XIX	Hospi tal	PPS	ı aiii
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
oust defited beschiption		To Charges	Program	Program Costs	
		10 onar ges	Charges	(col. 1 x col.	
			onal goo	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			6, 139, 739		30.00
31. 00 03100 INTENSIVE CARE UNIT			1, 858, 275		31.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			1, 638, 421		35. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY			206, 142		43.00
ANCILLARY SERVICE COST CENTERS		'			
50. 00 05000 OPERATING ROOM		0. 10769	6 1, 382, 677	148, 909	50.00
51. 00 05100 RECOVERY ROOM		0. 15306	6 176, 400	27, 001	51.00
52. OO 05200 DELIVERY ROOM & LABOR ROOM		0. 26493	2 536, 916	142, 246	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 10329	2 1, 224, 751	126, 507	54.00
57. 00 05700 CT SCAN		0.06202	1 622, 819	38, 628	57.00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 06484			59. 00
60. 00 06000 LABORATORY		0. 18615	· ·		60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 23246			63. 00
65. 00 06500 RESPIRATORY THERAPY		0. 23385		277, 102	65. 00
65. 01 06501 SLEEP LAB		0. 11770		0	65. 01
66. 00 06600 PHYSI CAL THERAPY		0. 41045		52, 470	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 41043		19, 071	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 22937		27, 241	68.00
68. 01 06801 AUDI OLOGY		0. 00000		27, 241	68. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 10754			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 10734			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 12738		33, 912	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 12730			73.00
73. 01 07301 HOSPI TAL BASED RETAIL PHARMACIES		1. 28289		032, 144	73.00
74. 00 07400 RENAL DI ALYSI S		0. 48877			74.00
76. 00 03160 CARDI OPULMONARY		0. 00000		73, 714	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 23113			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 10890		1 4,071	76. 98
77. 00 07700 ALLOGENEI C HSCT ACQUISITION		0. 00000		1	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000			78.00
OUTPATIENT SERVICE COST CENTERS		0.00000	.0		70.00
90. 00 09000 CLI NI C		0.00000	0	0	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC		1. 63607			90. 01
90. 02 09002 PAIN CLINIC		0. 68335		0	90. 02
90. 03 09003 0NCOLOGY CLINIC		0. 12457		6, 165	90. 03
91. 00 09100 EMERGENCY		0. 09519		210, 965	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 19844			92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0. 24441		0,001	92. 01
OTHER REIMBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVI CES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			15, 032, 301	2, 403, 253	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			15, 032, 301		202. 00

Heal th	Financial Systems BALL MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0089	Peri od:	Worksheet D-3	
		Component	CCN: 15-T089	From 01/01/2023 To 12/31/2023		pared:
		Ti tl	e XIX	Subprovi der -	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30. 00
31. 00	03100 I NTENSI VE CARE UNI T					31. 00
32. 00	03200 CORONARY CARE UNIT					32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT					35.00
40. 00 41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER -			200 244		40.00
43. 00	04300 NURSERY			280, 264		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 10769	96 0	0	50.00
51. 00	05100 RECOVERY ROOM		0. 15306			
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 26493			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 10329	92 0	0	54.00
57.00	05700 CT SCAN		0. 06202	21 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	00	_	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 06484		0	
60. 00	06000 LABORATORY		0. 18615		1	
60. 01	06001 BLOOD LABORATORY		0.00000			
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.		0. 23246		_	
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB		0. 23385		0	
66. 00	06600 PHYSI CAL THERAPY		0. 11770 0. 41045			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 24176		26, 519	1
68. 00	06800 SPEECH PATHOLOGY		0. 2293			
68. 01	06801 AUDI OLOGY		0.00000	·	0,701	
69. 00	06900 ELECTROCARDI OLOGY		0. 10754			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 22286		6, 946	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 12738	36 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 18125	59 116, 742	21, 161	73. 00
73. 01	07301 HOSPI TAL BASED RETAIL PHARMACIES		1. 28289		0	
74. 00	07400 RENAL DI ALYSI S		0. 48877			
76. 00	03160 CARDI OPULMONARY		0.00000			
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 23113			
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0. 10890			
77. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON		0.00000			
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	78. 00
90. 00	09000 CLINIC		0.00000	00 0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC		1. 63607			
	09002 PAIN CLINIC		0. 68335			1
90. 03	09003 ONCOLOGY CLINIC		0. 12457		Ō	
91.00	09100 EMERGENCY		0. 09350		0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 19844	17 O	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)		0. 2444	14 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS					

447, 559

447, 559

95.00

201. 00 202. 00

125, 886 200. 00

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

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

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

200.00

201.00

202.00

			10 12/31/2023	5/24/2024 9: 2	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		<u> </u>	1. 00	
1. 00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurri	na prior to October 1 (s	see	34, 172, 265	
	instructions)	ing price to october . (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 1, 1,2,200	
1.02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	l (see	11, 931, 453	1. 02
	instructions)				
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	r discharges occurring p	orior to October	0	1. 03
1 04	1 (see instructions)	r dicabargas accurring	n or often	0	1 04
1. 04	DRG for federal specific operating payment for Model 4 BPCl fo October 1 (see instructions)	a discharges occurring o	on or arter	U	1. 04
2. 00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		366, 705	2. 03
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		85, 114	2. 04
3.00	Managed Care Simulated Payments			42, 502, 961	3. 00
4.00	Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	277. 89	4. 00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting p	period ending on	50. 70	5. 00
	or before 12/31/1996. (see instructions)				
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the C			0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet th	e criteria for an add-oi	n to the cap for	0. 00	6. 00
4 24	new programs in accordance with 42 CFR 413.79(e)	n building window close	Nundor \$127 of	0. 00	6. 26
6. 26	Rural track program FTE cap limitation adjustment after the ca the CAA 2021 (see instructions)	p-building window crosed	under 9127 of	0.00	0. 20
7. 00	MMA Section 422 reduction amount to the IME cap as specified u	nder 42 CER 8412 105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 01
7.01	cost report straddles July 1, 2011 then see instructions.	42 OTK 3412. 103(1)(1)(1)	7) (B) (Z) 11 the	0.00	7.01
7. 02	Adjustment (increase or decrease) to the hospital's rural trac	k program FTE limitation	n(s) for rural	0.00	7. 02
	track programs with a rural track for Medicare GME affiliated				
	and 87 FR 49075 (August 10, 2022) (see instructions)	. 3	` ,		
8.00	Adjustment (increase or decrease) to the FTE count for allopat	hic and osteopathic prog	grams for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7	9(c)(2)(iv), 64 FR 26340) (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).			 -	
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ts under § 5503 of the <i>i</i>	ACA. If the cost	12. 00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hospital	0. 00	8. 02
0 21	under § 5506 of ACA. (see instructions)	to under \$124 of the CA	1 2021 (600	0.00	0 21
8. 21	The amount of increase if the hospital was awarded FTE cap slo instructions)	its under \$126 of the CA	4 2021 (See	0. 00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through	6 40 minus lines 7 and	7 01 nlus or	62. 70	9.00
7.00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.		7. 01, prus 01	02.70	7.00
10.00	FTE count for allopathic and osteopathic programs in the curre		ds	59. 10	10.00
11. 00	FTE count for residents in dental and podiatric programs.	. 3			11. 00
12.00	Current year allowable FTE (see instructions)			59. 10	12. 00
13.00	Total allowable FTE count for the prior year.			61. 27	13. 00
14.00	Total allowable FTE count for the penultimate year if that yea	r ended on or after Sep	tember 30, 1997,	62. 70	14. 00
	otherwise enter zero.				
15. 00	,				15. 00
16. 00	Adjustment for residents in initial years of the program (see				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	ure		0.00	1
18.00	Adjusted rolling average FTE count			61. 02	1
19. 00	Current year resident to bed ratio (line 18 divided by line 4)			0. 219583	
20.00	Prior year resident to bed ratio (see instructions)			0. 212304	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 212304	1
22. 00	IME payment adjustment (see instructions)			5, 047, 158	
22. 01	IME payment adjustment - Managed Care (see instructions)	of the MMA		4, 652, 969	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422		TD 412 10E	4.00	22.00
23.00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.	int cap stots under 42 ci	K 412. 103	4.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			-3. 60	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the L	ower of line 23 or line	24 (see	0.00	
20.00	instructions)	ower or time 25 or time	21 (300	0.00	20.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			5, 047, 158	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		4, 652, 969	
	Di sproporti onate Share Adjustment				1
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruc	tions)	5. 32	
31. 00	Percentage of Medicaid patient days (see instructions)			26. 86	
32. 00	Sum of lines 30 and 31			32. 18	
33. 00	Allowable disproportionate share percentage (see instructions)			15. 76	1
34. 00	Disproportionate share adjustment (see instructions)			1, 816, 486	34.00

CALCUI	Financial Systems BALL MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0089	Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet E Part A Date/Time Pre	
				5/24/2024 9: 2	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncomponented Caro Daymont Adjustment		1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		6 874 403 450	5, 938, 006, 757	35. 00
35. 00	Factor 3 (see instructions)		0. 000358160	0. 000335854	
35. 02	, ,		2, 462, 134	1, 994, 306	
35. 03	Pro rata share of the hospital UCP, including supplemental U	ICP (see instructions)	1, 841, 541	501, 301	35. 03
36. 00		(=== :,	2, 342, 842		36.00
	Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 throu			ĺ
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruc	ctions)	0		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
4E 00	days)	20)	0.00		45 00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line 4		0.00		45. 00 46. 00
47. 00	Subtotal (see instructions)	11.01)	55, 762, 023		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	03, 702, 023		48.00
10.00	only. (see instructions)	smarr rarar nospi tars			10.00
				Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instruction			60, 414, 992	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			4, 065, 633	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt	The state of the s		0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I	The 49 see Instructions).		2, 578, 410	1
54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			37, 193 36, 970	
54. 01	Islet isolation add-on payment			30, 770	54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.00
55. 01	Cellular therapy acquisition cost (see instructions)	,		0	55. 01
56.00	Cost of physicians' services in a teaching hospital (see int	ructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30 t	hrough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		24, 159	58. 00
59.00	Total (sum of amounts on lines 49 through 58)			67, 157, 357	
60.00	Primary payer payments			3, 717	
61. 00	Total amount payable for program beneficiaries (line 59 minu	ıs line 60)		67, 153, 640	
62.00	Deductibles billed to program beneficiaries			4, 757, 888	
63.00	Coinsurance billed to program beneficiaries			171, 200	
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			321, 079 208, 701	
66. 00	,	structions)		116, 822	
67. 00	_	4511 5115)		62, 433, 253	
68. 00		applicable to MS-DRGs (s	ee instructions)	02, 433, 233	
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70. 50
70. 75				0	70. 75
70. 87	Demonstration payment adjustment amount before sequestration	1		0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	structions)		= 1	70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.9
70. 92	Bundled Model 1 discount amount (see instructions)			0 -83, 874	70. 92 70. 93
70 02					. // 9.
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-74, 775	

Heal th	Financial Systems BALL MEMO	ORI AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0089	Peri od: From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (E the corresponding federal year for the period prior to			0	0	70. 96
′0. 97	Low volume adjustment for federal fiscal year (yyyy) (E the corresponding federal year for the period ending on			0	0	70. 97
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus	lines 69 & 70)			62, 274, 604	71.00
71. 01	Sequestration adjustment (see instructions)				1, 245, 492	71. 01
71 02	Domonetration payment adjustment amount after sequestra	ti on	1		0	71 02

71.01	sequestration adjustment (see instructions)		1, 243, 492	
71. 02	Demonstration payment adjustment amount after sequestration		0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs			71. 03
72.00	Interim payments		60, 695, 326	72. 00
72. 01	Interim payments-PARHM			72. 01
73.00	Tentative settlement (for contractor use only)		o	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)		- 1	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		333, 786	ł
7 1. 00	73)		1	' 1. 00
74. 01	Balance due provider/program-PARHM (see instructions)			74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with		1 177 714	•
75.00			1, 177, 716	/5.00
	CMS Pub. 15-2, chapter 1, §115.2			
00.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			00 00
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. 00
	plus 2.04 (see instructions)			
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0	
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0	, ,
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95. 00
96.00	Time value of money for capital related expenses (see instructions)		0	96. 00
		Prior to 10/1	On/After 10/1	
		1.00	2. 00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.000000000	0.0000000000	101. 00
	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment	<u>'</u>		
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment	-	_	
200 00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
200.0	Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Rei mbursement			
201 0	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
	Medicare discharges (see instructions)			202.00
	Case-mix adjustment factor (see instructions)			202.00
203.00		. E voor demonst		203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current	. 5-year delilons t	ration	
204.00	peri od)	1		204 00
	Medicare target amount			204. 00
	Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement	1		
	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
	Adjustment to Medicare IPPS payments (see instructions)		'	209. 00
210.00				
211. 00	Reserved for future use			210. 00
				210. 00 211. 00
	Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement			211. 00
212. 00	Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)			
	Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement			211. 00
213.00	Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)			211. 00 212. 00
213.00	Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)			211. 00 212. 00 213. 00
213.00	Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			211. 00 212. 00 213. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet E | From 01/01/2023 Part A Exhibit 4 | To 12/31/2023 Date/Time Prepared: 5/24/2024 9:21 am Provider CCN: 15-0089

					'	0 12/31/2023	5/24/2024 9: 2	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	0 1. 00	1. 00	2.00	3.00	4.00	5. 00 0	1. 00
1.00	payments	1.00	ď	0		, o	U	1.00
1. 01	DRG amounts other than outlier	1. 01	34, 172, 265	0	34, 172, 265		34, 172, 265	1. 01
	payments for discharges		0.1, 1.72, 200	· ·	0 1, 1, 2, 200		01/11/2/200	
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	11, 931, 453	0		11, 931, 453	11, 931, 453	1. 02
	payments for discharges							
	occurring on or after October							
	1		_	_	_		_	
1. 03	DRG for Federal specific	1. 03	0	0	C		0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to October 1							
1. 04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.04	operating payment for Model 4	1.04	ď	0		o o	O	1.04
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
	discharges (see instructions)							
2.01	Outlier payments for	2. 02	0	0	C	0	0	2. 01
	discharges for Model 4 BPCI							
2. 02	Outlier payments for	2. 03	366, 705	0	366, 705		366, 705	2. 02
	discharges occurring prior to							
2. 03	October 1 (see instructions)	2. 04	OF 114	0		OF 114	OF 114	2 02
∠. ∪3	Outlier payments for discharges occurring on or	2. 04	85, 114	0		85, 114	85, 114	2. 03
	after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	o	0		o	0	3. 00
	reconciliation							
4.00	Managed care simulated	3. 00	42, 502, 961	0	31, 939, 636	10, 563, 325	42, 502, 961	4.00
	payments							
	Indirect Medical Education Adj							
5.00	Amount from Worksheet E, Part	21. 00	0. 212304	0. 212304	0. 212304	0. 212304		5. 00
	A, line 21 (see instructions)	22.00	E 047 1E0	0	2 740 074	1 20/ 10/	E 047 1E0	4 00
6. 00	IME payment adjustment (see instructions)	22. 00	5, 047, 158	0	3, 740, 974	1, 306, 184	5, 047, 158	6. 00
6. 01	IME payment adjustment for	22. 01	4, 652, 969	0	3, 496, 560	1, 156, 409	4, 652, 969	6. 01
0.01	managed care (see	22.01	4,032,707	0	3, 470, 300	1, 130, 407	4, 032, 707	0.01
	instructions)							
	Indirect Medical Education Adj	ustment for the	Add-on for Se	ction 422 of t	he MMA	'		
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.000000	0. 000000		7. 00
	(see instructions)							
8.00	IME adjustment (see	28. 00	0	0	C	0	0	8. 00
0.04	instructions)	00.04						0.01
8. 01	IME payment adjustment add on	28. 01	U	0		0	0	8. 01
	for managed care (see instructions)							
9. 00	Total IME payment (sum of	29. 00	5, 047, 158	0	3, 740, 974	1, 306, 184	5, 047, 158	9. 00
7. 00	lines 6 and 8)	27.00	5, 547, 156	0	5, 740, 774	1, 300, 104	5, 047, 130	7.00
9. 01	Total IME payment for managed	29. 01	4, 652, 969	0	3, 496, 560	1, 156, 409	4, 652, 969	9. 01
	care (sum of lines 6.01 and							
	8. 01)							
	Disproportionate Share Adjustm				ı			
10. 00	Allowable disproportionate	33. 00	0. 1576	0. 1576	0. 1576	0. 1576		10. 00
	share percentage (see							
11. 00	instructions) Disproportionate share	24.00	1 01/ 40/	0	1 244 207	470.000	1 01/ 40/	11 00
11.00	adjustment (see instructions)	34.00	1, 816, 486	U	1, 346, 387	470, 099	1, 816, 486	11.00
11. 01	Uncompensated care payments	36.00	2, 342, 842	0	1, 841, 541	501, 301	2, 342, 842	11. 01
11.01	Additional payment for high pe				1,041,341	301, 301	2, 342, 042	11.01
12. 00	Total ESRD additional payment	46.00	ol serierrerary	0	C	0	0	12. 00
00	(see instructions)		Ĭ	O			Ĭ	
13.00	Subtotal (see instructions)	47.00	55, 762, 023	0	41, 467, 872	14, 294, 151	55, 762, 023	13.00
14.00	Hospital specific payments	48. 00	О	0	C	ol	0	14. 00
	(completed by SCH and MDH,							
	small rural hospitals only.)							
a = · ·	(see instructions)						,	
15. 00	Total payment for inpatient	49. 00	60, 414, 992	0	44, 964, 432	15, 450, 560	60, 414, 992	15. 00
	operating costs (see							
14 00	instructions)	EO 00	4 045 433	^	2 007 040	1 047 770	4 O/E /33	14 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	4, 065, 633	0	2, 997, 860	1, 067, 773	4, 065, 633	10.00
	if applicable)							
	,	1	ı I		ı	1 1		

12/31/2023 Date/Time Prepared: 5/24/2024 9: 21 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od E, Part A) On/After 10/01 to 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 36, 970 36, 970 36, 970 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 47, 999, 262 16, 518, 333 64, 517, 595 19.00 W/S L, line (Amounts from L) 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 3, 497, 727 2, 576, 624 921, 103 3, 497, 727 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 17, 364 15, 675 1,689 17, 364 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22.00 5.00 0.0900 0.0900 0.0900 0.0900 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 314, 795 231, 896 82, 899 314, 795 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0674 0.0674 0.0674 0.0674 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 235, 747 Ω 62.082 235, 747 25.00 173, 665 adjustment (see instructions) 26.00 Total prospective capital 12.00 4,065,633 2, 997, 860 1, 067, 773 4,065,633 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2. 00 5. 00 1.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00

adjustments to Wkst. E, Pt. A.

From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/24/2024 9:21 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 34, 172, 265 34, 172, 265 34, 172, 265 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 11, 931, 453 1.02 11, 931, 453 11, 931, 453 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 366, 705 366, 705 366, 705 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 85, 114 85, 114 85, 114 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 42, 502, 961 31, 939, 636 10, 563, 325 42, 502, 961 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0. 212304 0.212304 0. 212304 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 5, 047, 158 3, 740, 974 1, 306, 184 5, 047, 158 6.00 3, 496, 560 1, 156, 409 4, 652, 969 6.01 IME payment adjustment for managed care (see 22.01 4, 652, 969 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.000000 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 5, 047, 158 3, 740, 974 1, 306, 184 5, 047, 158 9.00 Total IME payment for managed care (sum of 9.01 29.01 4, 652, 969 3, 496, 560 1, 156, 409 4, 652, 969 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1576 0.1576 0.1576 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1, 816, 486 1.346.387 470.099 1.816.486 11.00 instructions) 11.01 Uncompensated care payments 36, 00 2, 342, 842 1, 841, 541 501, 301 2, 342, 842 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 55, 762, 023 41, 467, 872 Subtotal (see instructions) 14, 294, 151 55, 762, 023 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 60, 414, 992 15, 450, 560 60, 414, 992 15.00 15.00 44, 964, 432 (see instructions) 2, 997, 860 16.00 50 00 4.065,633 1, 067, 773 4, 065, 633 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 36, 970 36, 970 36, 970 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 C 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions) 64, 517, 595 19. 00 19.00 SUBTOTAL 47, 999, 262 16, 518, 333

Heal th	Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 9:2	pared:
				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	3, 497, 727	2, 576, 62	4 921, 103	3, 497, 727	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2.00	17, 364	15, 67	1, 689	17, 364	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0900	0. 090	0. 0900		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	314, 795	231, 89	6 82, 899	314, 795	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0674	0. 067	0.0674		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	235, 747	173, 66	62, 082	235, 747	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	4, 065, 633	2, 997, 86	1, 067, 773	4, 065, 633	26. 00
	,	Wkst. E, Pt.	(Amt. from				
		A, 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	
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	-83, 874		0 -83, 874	-83, 874	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-74, 775	-34, 20	-40, 567	-74, 775	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0		0	0	31. 01

0

70. 99

1.00

Ν

2.00

0

3. 00

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

100. 00

0 32. 00

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

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

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089		Worksheet E Part B Date/Time Prepared: 5/24/2024 9:21 am
	T		550

	T; Al -	VA/LLL	11: +-1	5/24/2024 9: 2	<u>1 am</u>
		XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			13, 161	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)			45, 248, 904	2.00
3.00	OPPS or REH payments Outlier payment (see instructions)			43, 288, 781	3. 00 4. 00
4. 00 4. 01	Outlier reconciliation amount (see instructions)			154, 147 0	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5. 00
6. 00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs including REH direct graduate	medical educa	ation costs from	82, 850	9. 00
10.00	Wkst. D, Pt. IV, col. 13, line 200			0	10 00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 13, 161	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			13, 101	11.00
	Reasonable charges				
12.00	Ancillary service charges			73, 351	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			73, 351	14. 00
45.00	Customary charges	.		0	45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for Amounts that would have been realized from patients liable for payment fo			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	i services or	ii a ciiai gebasi s	U	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			73, 351	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 1	8 exceeds lin	ne 11) (see	60, 190	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only if line 1	1 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			13, 161	21. 00
22. 00	Interns and residents (see instructions)			13, 101	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			43, 525, 778	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CA			7, 165, 245	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum	of lines 22	and 23] (see	36, 373, 694	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)			1, 891, 393	28. 00
28. 50	REH facility payment amount (see instructions)			1, 071, 373	28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30. 00	Subtotal (sum of lines 27, 28, 28.50 and 29)			38, 265, 087	
31.00	Primary payer payments			48, 927	31.00
32. 00	Subtotal (line 30 minus line 31)			38, 216, 160	32.00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0	00.00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 522, 401	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			339, 561	
	Allowable bad debts for dual eligible beneficiaries (see instructions)			245, 105	36.00
37. 00	Subtotal (see instructions)			38, 555, 721	
38. 00	MSP-LCC reconciliation amount from PS&R			-6, 713	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			_ :	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices	(See instruc	tions)	0	39. 97 39. 98
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	(See This truc	1 0113)	0	39. 90
40. 00	Subtotal (see instructions)			38, 562, 434	40.00
40. 01	Sequestration adjustment (see instructions)			771, 249	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41. 00	Interim payments			37, 692, 379	41.00
41. 01	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			U	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			98, 806	
43. 01	Balance due provider/program-PARHM (see instructions)			,0,000	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS	Pub. 15-2,	chapter 1,	97, 799	44. 00
	§115. 2			·	
0-	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00
	Time Value of Money (see instructions)				93.00
			l		

Health Financial Systems	BALL MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0089	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pro	epared:
				5/24/2024 9: 2	<u>rıam</u>
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				C	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				C	200. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Period: Worksheet E From 01/01/2023 Part B
		To 12/31/2023 Date/Time Prepared: 5/24/2024 9:21 am

		Component Colv. 13 1007	10 12/31/2023	5/24/2024 9: 2	
		Title XVIII	Subprovi der - I RF	PPS	
			TNI		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			403	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc-	ti ons)		39	2. 00
3.00	OPPS or REH payments			168	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)	-4!>		0	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	ctions)		0.000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs including REH direc	ct graduate medical educa	ation costs from	0	9. 00
	Wkst. D, Pt. IV, col. 13, line 200			_	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			403	11. 00
	Reasonable charges				
12.00	Ancillary service charges			2, 224	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			2, 224	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for patients liable for patients liable.	nayment for services on	a chargo basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for				16. 00
	had such payment been made in accordance with 42 CFR §413.13(. 3	. a ona gozaoi o		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			2, 224	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	ly if line 18 exceeds lin	ne 11) (see	1, 821	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete onl</pre>	lv if line 11 evceeds lin	ne 18) (see	0	20. 00
20.00	instructions)	Ty IT TITLE IT EXCECUS ITT	10 (300	ا	20.00
21. 00	Lesser of cost or charges (see instructions)			403	21.00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			168	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line		uctions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	571	27. 00
20.00	instructions)	ino FO)			20.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, li REH facility payment amount (see instructions)	The 50)		0	28. 00 28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			571	
31. 00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31)	250)		571	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	JES)		0	33. 00
	Allowable bad debts (see instructions)			0	34. 00
	Adjusted reimbursable bad debts (see instructions)			Ō	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36. 00
37. 00	Subtotal (see instructions)			571	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	c)		ا	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	3)		0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			Ö	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			571	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			11	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs			ا	40. 02
41. 00	Interim payments			601	
	Interim payments-PARHM				41. 01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-41	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	chapter 1.	0	44. 00
00	§115. 2			<u> </u>	55
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
72.00	I me rate used to caredrate the fille value of molley			. 0.00	72.00

Health Financial Systems	BALL MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0089	Peri od:	Worksheet E	
		0 1 00N 45 7000	From 01/01/2023		
		Component CCN: 15-T089	To 12/31/2023		
				5/24/2024 9: 2	ı am
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1. 00	
93.00 Time Value of Money (see instructions)			·	0	93. 00
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Health Financial Systems BAANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0089

			'	0 12/31/2023	5/24/2024 9: 2	
		Title	xVIII	Hospi tal	PPS	
		Inpatien	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11.00	60, 695, 326		37, 692, 379	1. 00
2. 00	Interim payments payable on individual bills, either		00, 070, 020		07,072,077	2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	<u> </u>	1	II.		
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3. 02			1 0		0	3. 02
3. 03					0	3. 03
3. 04						3. 04
3. 05						3.05
3.03	Provider to Program				0	3.00
3.50	ADJUSTMENTS TO PROGRAM		1 0		0	3.50
3. 51	ADJUSTIMENTS TO FROUKAM					3. 51
3. 52						3. 52
3. 52						3. 52
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 99
3. 99	3. 50-3. 98)		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		60, 695, 326		37, 692, 379	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		00, 075, 320		31,092,319	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
5.00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		1 0		0	5. 01
5. 02	TENTAL TO TROVIDER					5. 02
5. 03						5. 03
0.00	Provider to Program					0.00
5. 50	TENTATI VE TO PROGRAM		1 0		0	5. 50
5. 51	TENTATI VE TO TROCKAW					5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
J. 77	5. 50-5. 98)					J. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		333, 786		98, 806	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 000,700		70,000	6. 02
7.00	Total Medicare program liability (see instructions)		61, 029, 112		37, 791, 185	7. 00
7.00	Trotal mode out of program traditity (see this traditions)		01,027,112	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 00	Tham of contractor	I		T .	1	0.00

Provider CCN: 15-0089 Component CCN: 15-T089 Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		3, 335, 353		601	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		C	,	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER		C	ı	0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER				0	3. 01 3. 02
3. 02			0			3. 02
3. 04			O		l ől	3. 04
3. 05			Ö		l ol	3. 05
	Provider to Program			"		
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3.53			0		0	3. 53
3.54	Subtatal (our of lines 2 01 2 40 minus our of lines		0		0 0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		U	,	ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 335, 353		601	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		0,000,000			1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C	1	0	5. 01
5. 02	TENTATI VE TO TROVIDER		0			5. 02
5. 03			Ö		l ol	5. 03
	Provider to Program				•	
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		45, 010)	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		41	6. 02
7.00	Total Medicare program liability (see instructions)		3, 380, 363		560	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2.00	8. 00
0.00	Name of Contractor			1	ı l	o. UU

Heal th	Financial Systems BALL MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0089	Peri od: From 01/01/2023	Worksheet E-1	
			To 12/31/2023	Date/Time Pre	
				5/24/2024 9: 2	<u> 1 am </u>
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				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	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089	Peri od: From 01/01/2023	Worksheet E-3
	Component CCN: 15-T089		Date/Time Prepared: 5/24/2024 9:21 am
	Title XVIII	Subprovi der -	PPS
		IRF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	3, 254, 913	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0320	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	179, 671	3.00
4.00	Outlier Payments	41, 954	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. 00
10.00	Average Daily Census (see instructions)	13. 276712	
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3, 476, 538	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3, 476, 538	17.00
18. 00	Pri mary payer payments	0	18.00
19. 00	Subtotal (line 17 less line 18).	3, 476, 538	19.00
20.00	Deducti bl es	27, 200	20.00
21. 00	Subtotal (line 19 minus line 20)	3, 449, 338	21.00
22. 00	Coi nsurance	6, 400	
23. 00	Subtotal (line 21 minus line 22)	3, 442, 938	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8, 904	24.00
25. 00	Adjusted reimbursable bad debts (see instructions)	5, 788	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27. 00	Subtotal (sum of lines 23 and 25)	3, 448, 726	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)	624	29. 00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 98	Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	3, 449, 350	
32. 01	Sequestration adjustment (see instructions)	68, 987	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	3, 335, 353	33. 00
34. 00	Tentative settlement (for contractor use only)	0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	45, 010	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	142, 565	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	41, 954	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE THE COVID-19 PHE)	END OF	
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99. 00
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	99. 01

	Financial Systems BALL MEMORIAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO	CN: 15-0089	Period:	Worksheet E-4	
EDI CAI	L EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre	
		Title	XVIII	Hospi tal	5/24/2024 9: 2° PPS	ı am
		11 (10		noop: ea.		
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1. 00	
. 00	Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	na periods	57. 92	1 1. C
	ending on or before December 31, 1996.	programe ron	0001 . opo. t.	ng pontous	07.72	'' '
01	FTE cap adjustment under §131 of the CAA 2021 (see instruction	ons)			0. 00	1. (
00	Unweighted FTE resident cap add-on for new programs per 42 CF				0.00	
26	Rural track program FTE cap limitation adjustment after the c	cap-bui I di ng	window closed	d under §127 of	0. 00	2.
00	the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MN	10			0. 00	3.
01	Direct GME cap reduction amount under ACA §5503 in accordance		8/113 70 (m)	(500	0.00	
01	instructions for cost reporting periods straddling 7/1/2011)	WITH 42 OIK	3413.77 (111).	(366	0.00] 3.
02	Adjustment (increase or decrease) to the hospital's rural tra	ack FTE limit	ation(s) for	rural track	0. 00	3.
	programs with a rural track Medicare GME affiliation agreemen					
	49075 (August 10, 2022) (see instructions)					
00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0. 00	4.
01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		agat manamti	na nori odo	12.00	1
01	ACA Section 5503 increase to the Direct GME FTE Cap (see instantial straddling 7/1/2011)	Tructions for	cost reporti	ng perrous	12. 00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slot	ts (see inst	ructions for	cost reporting	0.00	4.
	periods straddling 7/1/2011)	(5		
21	The amount of increase if the hospital was awarded FTE cap sl	ots under §1	26 of the CAA	1 2021 (see	0.00	4.
	instructions)					_
00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lin			nus lines 3 and	69. 92	5.
00	3.01, plus or minus line 3.02, plus or minus line 4, plus lir Unweighted resident FTE count for allopathic and osteopathic			woor from wour	59. 10	6.
00	records (see instructions)	programs ror	the current	year from your	59. 10	0.
00	Enter the lesser of line 5 or line 6				59. 10	7.
			Pri mary Care	e Other	Total	
			1. 00	2. 00	3. 00	
00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	1.00		3. 00 59. 10	8.
	program for the current year.		48.	11.00	59. 10	
	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	vi se		11.00		
	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 9 divided by the amount from line 8 times the result of line 9 divided by the amount from line 8 divided	vise ount on line	48.	11.00	59. 10	
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1	vise ount on line	48.	11.00	59. 10	
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 9 divided by the amount from line 8 times the result of line 9 divided by the amount from line 8 divided	vise ount on line 1, 2022, or	48.	11.00	59. 10	9.
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount from 1 to 2 to 2 to 2 to 2 to 2 to 2 to 2 to	vise ount on line 1, 2022, or cent year	48. ·	10 11.00 10 11.00 0.00 0.00	59. 10	9. 10. 10.
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount from 1 to 1 to 2 to 2 to 2 to 2 to 2 to 2 to	vise Dunt on line 1, 2022, or Tent year Jurrent year	48. · 48. ·	10 11.00 10 11.00 0.00 0.00 10 11.00	59. 10	9. 10. 10. 11.
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current line in the current weighted for the current line in the current line is the count for the current line is the current line in the current line is the current line in the current line is the current line in the current line is the current line in the current line is the current line	vise Dunt on line 1, 2022, or Tent year Jurrent year	48. ·	10 11.00 10 11.00 0.00 0.00 10 11.00	59. 10	9. 10. 10. 11.
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RECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der 0	CCN: 15-0089	Peri od:	Worksheet E-4	
DI CAL EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 9:2	
	Ti tl	e XVIII	Hospi tal	PPS	
		Inpatient Pa A	rt Managed Care	Total	
		1.00	2. 00	3. 00	
COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
ON Inpatient Days (see instructions) (Title XIX - see S-2 Par 3.02, column 2)	rt IX, line	23, 1	35 23, 083		26. 0
00 Total Inpatient Days (see instructions)		77, 7	32 77, 732		27. 0
On Ratio of inpatient days to total inpatient days		0. 2976			28.0
OD Program direct GME amount		2, 274, 5		4, 544, 014	
01 Percent reduction for MA DGME		_,_,,,,	3. 27	., ,	29.0
00 Reduction for direct GME payments for Medicare Advantage			74, 211	74, 211	30.0
00 Net Program direct GME amount				4, 469, 803	31.0
				1. 00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - 7 EDUCATION COSTS)	FITLE XVIII ONL	Y (NURSING PRO	OGRAM AND PARAMED	OI CAL	
Renal dialysis direct medical education costs (from Wkst. and 94)	B, Pt. I, sum o	of col. 20 and	d 23, lines 74	0	32.0
00 Renal dialysis and home dialysis total charges (Wkst. C, I	Pt. I. col. 8. :	sum of lines	74 and 94)	4, 331, 344	33.0
00 Ratio of direct medical education costs to total charges			,	0. 000000	
00 Medicare outpatient ESRD charges (see instructions)	•	•		0	35. C
00 Medicare outpatient ESRD direct medical education costs (line 34 x line :	35)		0	36.0
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XV	/III ONLY]
Part A Reasonable Cost					1
00 Reasonable cost (see instructions)				61, 753, 299	1
00 Organ acquisition and HSCT acquisition costs (see instruc				0	
OO Cost of physicians' services in a teaching hospital (see	instructions)			0	39.0
OD Primary payer payments (see instructions)				3, 717	
OD Total Part A reasonable cost (sum of lines 37 through 39 i	minus iine 40)			61, 749, 582	41. 0
Part B Reasonable Cost Reasonable cost (see instructions)				45, 345, 357	42. C
00 Primary payer payments (see instructions)				43, 343, 337	
00 Total Part B reasonable cost (line 42 minus line 43)				45, 296, 430	
00 Total reasonable cost (sum of lines 41 and 44)				107, 046, 012	
00 Ratio of Part A reasonable cost to total reasonable cost	(line 41 ÷ line	45)		0. 576851	
On Ratio of Part B reasonable cost to total reasonable cost				0. 423149	
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND		<i></i>			Ī
OO Total program GME payment (line 31)				4, 469, 803	48. C
00 Part A Medicare GME payment (line 46 x 48) (title XVIII or				2, 578, 410	
00 Part B Medicare GME payment (line 47 x 48) (title XVIII or	alv) (ass : note	ictions)		1, 891, 393	I EO O

Heal th	Financial Systems BALL MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2	552-10
OUTLI E			Worksheet E-5		
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 9:21	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	tions)		0	4.00
5.00	The rate used to calculate the time value of money (see instr	uctions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)			0	6.00
7.00	Time value of money for capital related expenses (see instruc	tions)		0	7.00

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

Health Financial Systems

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

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 9: 21 am

onl y)			'	0 12/31/2023	5/24/2024 9: 2	
		General Fund		Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3. 00	4.00	
1.00	Cash on hand in banks	404, 958, 255		0	0	
2.00	Temporary investments	0	1	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	0 70, 846, 073	1	0	0	1
5.00	Other recei vable	4, 578, 822		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	0	Ö	0	0	
7.00	Inventory	13, 863, 964	0	0	0	7. 00
8. 00	Prepai d expenses	1, 203, 293	0	0	0	
9.00	Other current assets		0	0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	495, 450, 407	1	0	0	1
11.00	FIXED ASSETS	473, 430, 407		<u> </u>	0	111.00
12.00	Land	6, 072, 523	0	0	0	12. 00
13.00	Land improvements	3, 429, 715	1	0	0	13. 00
14. 00	Accumulated depreciation	-3, 313, 112	1	0	0	
15.00	Buildings	417, 478, 617	1	0	0	
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-250, 786, 633 429, 120	1	0	0	1
18. 00	Accumul ated depreciation	-414, 593	1	ő	Ö	
19. 00	Fi xed equipment	0	1	0	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00 23. 00	Accumulated depreciation Major movable equipment	154, 731, 628		0	0	
24. 00	Accumulated depreciation	-115, 191, 646	1	0	0	1
25. 00	Mi nor equipment depreciable	0	Ö	Ö	Ö	
26. 00	Accumulated depreciation	O	0	0	0	
27. 00	HIT designated Assets	0	0	0	0	1
28. 00 29. 00	Accumulated depreciation	0	0	0	0	28. 00 29. 00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	212, 435, 619		0	0	30.00
30.00	OTHER ASSETS	212, 433, 017		<u> </u>		30.00
31.00	Investments	134, 690, 068	0	0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	
33.00	Due from owners/officers	21, 383, 946	1	0	0	1
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	156, 074, 014	0	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	863, 960, 040	1	ő	0	1
	CURRENT LIABILITIES					
37. 00	Accounts payable	32, 318, 574	1	0	0	
38. 00	Salaries, wages, and fees payable	8, 127, 049	1	0	0	
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	621, 719 156, 159	1	0	0	
41. 00	Deferred income	130, 137		0	0	
42.00	Accel erated payments	2, 986, 633	3	-		42.00
43.00	Due to other funds	10, 467, 114		0	0	
44.00	Other current liabilities	0			0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	54, 677, 248	0	0	0	45. 00
46. 00	Mortgage payable	0	0	O	0	46. 00
47. 00	Notes payable	Ö	1	Ö	Ö	
48. 00	Unsecured Loans	O	0	0	0	
49. 00	Other long term liabilities	1, 654, 938		0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 654, 938	1	0	0	
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	56, 332, 186	0	<u> </u>	0	31.00
52.00	General fund balance	807, 627, 854				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	807, 627, 854		0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	863, 960, 040	0	0	0	60.00
	l~'/	ı	I	ı	ı	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES BALL MEMORIAL HOSPITAL

Period: Worksheet G-1 Provider CCN: 15-0089

					From 01/01/202 To 12/31/202		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		747, 501, 686			0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		59, 807, 369 807, 309, 055			0	2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		807, 309, 055		0	0	3. 00 4. 00
5. 00	DONATED PPE	127, 455			0	0	5. 00
6. 00	50.011.25 11.2	0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		127, 455			0	10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		807, 436, 510		0	0	11. 00 12. 00
13. 00	RESTRICTED FUND BALANCE	-191, 347			0	0	13. 00
14. 00	ROUNDI NG	3			0	o o	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		-191, 344	l .		0	18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		807, 627, 854			٥	19. 00
	Janear (Trite Triminas Trite To)	Endowment Fund	PI ant	Fund			
1 00	Fund halanges at heat anima of nemind	6.00	7. 00	8. 00	0		1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)				0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00	DONATED PPE		0				5. 00
6. 00			0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	0	O		0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12. 00
13.00	RESTRICTED FUND BALANCE		0				13. 00
14.00	ROUNDI NG		0				14.00
15. 00 16. 00			0				15. 00 16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	0		0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

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

			0 12/31/2023	5/24/2024 9:2	
	Cost Center Description	Inpati ent	Outpati ent	Total	ı diii
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	210, 341, 430	b	210, 341, 436	1. 00
2.00	SUBPROVI DER - I PF			0	2. 00
3.00	SUBPROVI DER - I RF	13, 004, 438	3	13, 004, 438	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	223, 345, 87	ļ.	223, 345, 874	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	60, 827, 05!	5	60, 827, 055	11. 00
12.00	CORONARY CARE UNIT)	0	12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	14, 653, 98	3	14, 653, 983	15. 00
16.00	Total intensive care type inpatient hospital services (sum of line	es 75, 481, 038	3	75, 481, 038	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	298, 826, 912		298, 826, 912	17. 00
18. 00	Ancillary services		1, 103, 138, 839		18. 00
19. 00	Outpati ent servi ces	81, 391, 01			19. 00
20. 00	RURAL HEALTH CLINIC		1	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	NRCC	<u> </u>	1, 759, 638		27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to V	Vkst. 1,016,679,34°	1, 449, 548, 523	2, 466, 227, 864	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		F10, 007, 44E	Г	20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		518, 926, 445		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32. 00			1		32.00
33. 00					33.00
34. 00					34.00
35. 00	T-t-1 -dditi (6 line- 20 25)	'			35. 00
36.00	Total additions (sum of lines 30-35)		J		36.00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00 39. 00			1		38. 00 39. 00
		· · · · · · · · · · · · · · · · · · ·	1		
40. 00 41. 00					40. 00 41. 00
41.00	Total deductions (sum of lines 37-41)	1	΄		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	ransfor	518, 926, 445		42.00
43.00	to Wkst. G-3, line 4)		510, 720, 443		43.00
	TO MINST. O O, TITLE 4)	ı	I	I	I

	Financial Systems BALL MEMORENT OF REVENUES AND EXPENSES	Provider CCN: 15-0089	Peri od:	u of Form CMS-2 Worksheet G-3	
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0089	From 01/01/2023	worksneet G-3	
			To 12/31/2023	Date/Time Pre	pared:
	<u> </u>			5/24/2024 9: 2	1 am
		>		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			2, 466, 227, 864	
2.00	Less contractual allowances and discounts on patients' ac	ccounts		1, 927, 319, 961	
3.00	Net patient revenues (line 1 minus line 2)			538, 907, 903	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I			518, 926, 445	
5.00	Net income from service to patients (line 3 minus line 4))		19, 981, 458	5.00
	OTHER I NCOME			0	
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communica	ation services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase discounts			0	
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	1
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters				15.00
	Revenue from sale of medical and surgical supplies to oth	ner than patients			16. 00
	Revenue from sale of drugs to other than patients				17. 00
	Revenue from sale of medical records and abstracts				18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
	Rental of hospital space			0	
	Governmental appropriations			0	
	MI SCELLANEOUS I NCOME			39, 825, 911	
	COVI D-19 PHE Fundi ng			0	
	Total other income (sum of lines 6-24)			39, 825, 911	
	Total (line 5 plus line 25)			59, 807, 369	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	
29.00	Net income (or loss) for the period (line 26 minus line 2	28)		59, 807, 369	29. 00

1.00	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0089	Peri od: From 01/01/2023	Worksheet L	
1.00			To 12/31/2023	Parts I-III Date/Time Prep 5/24/2024 9:2	
1.00		Title XVIII	Hospi tal	PPS	ı allı
1.00					
1.00	DART I FILLY PROCECTIVE METHOD			1. 00	
1.00	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
	Capital DRG other than outlier			3, 497, 727	1.00
	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			17, 364	2. 00
	Model 4 BPCI Capital DRG outlier payments			0	2. 01
	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	199. 69	3. 00
	Number of interns & residents (see instructions)			61. 02	4. 00
5. 00 6. 00	Indirect medical education percentage (see instructions)	sum of lines 1 and 1 01	columns 1 and	9. 00 314, 795	5. 00 6. 00
6.00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum of fines fand for	, corumns r and	314, 795	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	oatient days (Worksheet E	, part A line	5. 32	7. 00
8.00	Percentage of Medicaid patient days to total days (see instru	uctions)		26. 86	8. 00
9.00	Sum of lines 7 and 8			32. 18	9. 00
	Allowable disproportionate share percentage (see instructions	5)		6. 74	10.00
	Disproportionate share adjustment (see instructions)			235, 747	11.00
12.00	Total prospective capital payments (see instructions)			4, 065, 633	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
	Program inpatient routine capital cost (see instructions)			0	1. 00
	Program inpatient ancillary capital cost (see instructions)			0	2. 00
	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
1	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00
3.00	Total Tripatrent program capital cost (Trile 3 x Trile 4)			U	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)	(!+		0	1.00
	Program inpatient capital costs for extraordinary circumstand Net program inpatient capital costs (line 1 minus line 2)	ces (see instructions)		0	2. 00 3. 00
	Applicable exception percentage (see instructions)			0. 00	4. 00
	Capital cost for comparison to payments (line 3 x line 4)			0.00	5.00
	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0. 00	6. 00
	Adjustment to capital minimum payment level for extraordinary		: line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
	Current year capital payments (from Part I, line 12, as appli			0	9. 00
	Current year comparison of capital minimum payment level to c			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L. Part III, line 14)	capital payment (from pri	or year	0	11. 00
12. 00	Worksheet E, Part III, Time 14) Net comparison of capital minimum payment level to capital pa	avments (line 10 plus lin	ie 11)	0	12. 00
	Current year exception payment (if line 12 is positive, enter			0	13.00
	Carryover of accumulated capital minimum payment level over of			0	14. 00
	(if line 12 is negative, enter the amount on this line)				
	Current year allowable operating and capital payment (see ins	structions)		0	15.00
	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)			0	16. 00 17. 00