Heal th Financia	al Systems	MARION GENERAL HO	SPI TAL	In Lie	eu of Form CMS-2552-10
	required by law (42 USC 1395 since the beginning of the co				FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX C SUMMARY	OST REPORT CERTIFICATION	Provi der CCN: 1500	011 Peri od: From 07/01/2014 To 06/30/2015	
PART I - COST	REPORT STATUS				
Provi der use only	1. [X] Electronically filed 2. [] Manually submitted co 3. [O] If this is an amended 4. [F] Medicare Utilization.	st report I report enter the number of	f times the provide for low.	Date: 11/23/2 er resubmitted this c	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN		

PART II - CERTIFICATION

(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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARION GENERAL HOSPITAL (150011) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 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.

(Si gned)					
	Offi cer	or Adm	i ni strator	of Provider(s	s)
Title					
Date					

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-453, 221	182, 920	352, 991	-491, 991	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-18, 229	0		34, 625	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	-471, 450	182, 920	352, 991	-457, 366	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10

Heal th	Financial Systems	MARI ON	GENERAL	HOSPI TA	.L		11	n Lieu	of For	m CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DA	λΤΑ	Prov	ider CCN		Period: From 07/01/ To 06/30/	/2014 F /2015 D	lorkshe Part I Date/Ti	et S-2 me Pre	pared:
	1.00	2.	. 00		3. 00			4. 00	1/23/2	015 /:	14 am
	Hospital and Hospital Health Care Co										
1. 00 2. 00	Street: 441 WABASH AVENUE City: MARION	PO Box: State: I	I N	Zin Cod	e: 46952-	Count	y: GRANT				1. 00 2. 00
2.00	orty. Water on	Component Na		CCN	CBSA	Provi der		Paymen	t Syste	em (P,	2.00
		·		Number	Number	Туре	Certi fi ed		0, or		
		1.00		2. 00	3.00	4.00	5. 00	V 6. 00	7. 00	XI X 8. 00	
	Hospital and Hospital-Based Componen		 :	2.00	3.00	4.00	5.00	0.00	7.00	8.00	
3.00	Hospi tal	MARION GENERAL H		150011	99915	1	07/01/1966	N	Р	0	3. 00
4.00	Subprovi der - IPF		0001.741	457044	00045	_	07/04/0005				4. 00
5. 00	Subprovi der - IRF	MARION GENERAL H	OSPI TAL	15T011	99915	5	07/01/2005	N	Р	0	5. 00
6.00	Subprovi der - (Other)										6. 00
7. 00	Swing Beds - SNF										7. 00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF										8. 00 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 14. 00	Separatel y Certi fi ed ASC Hospi tal -Based Hospi ce										13. 00 14. 00
15. 00	Hospital -Based Health Clinic - RHC										15. 00
16.00	Hospital-Based Health Clinic - FQHC										16.00
	Hospital - Based (CMHC) I										17. 00
18. 00 19. 00	Renal Dialysis Other				-						18. 00 19. 00
		ı			1		From:		To:		
20.00	Cook Donard: an Donied (may/dd/may)						1.00		2.0		20.00
20. 00 21. 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						07/01/2	014	06/30/	2015	20. 00 21. 00
200	Inpatient PPS Information										21.00
22. 00	Does this facility qualify and is it						Y		N		22. 00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				12.00(0)(2) (I I CKI 6					
22. 01	Did this hospital receive interim un						N		Υ		22. 01
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)		Ü								
22. 02	Is this a newly merged hospital that determined at cost report settlement						N N		N		22. 02
	or "N" for no, for the portion of th	•	,			,	^				
	in column 2, "Y" for yes or "N" for	no, for the porti	on of th	e cost ı	reporting	period o	n				
22.02	or after October 1. Did this hospital receive a geograph	i a rool assificati	on from	urban ta	rural a	e a rocul:	t N		N		22. 03
22.03	of the OMB standards for delineating						L IN		IN		22. 03
	in column 1, "Y" for yes or "N" for	no for the portio	on of the	cost re	eporting	peri od					
	prior to October 1. Enter in column cost reporting period occurring on o						9				
	hospital contain at least 100 but no						n				
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N	N" for no								
23. 00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							3	N		23. 00
	method of identifying the days in th										
	used in the prior cost reporting per	iod? In column 2						11:: -	1 04	- l	
			In-State Medicai			Out-of State		ledicaid IMO days		her i cai d	
			pai d day				Medi cai d			ays	
						id days 6	eligible				
			1.00		ys 00	3. 00	unpai d 4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital	, enter the	1, 00		999	3.00	4.00	2, 2			24. 00
	in-state Medicaid paid days in colum	n 1, in-state						•			
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicald paid days in cout-of-state Medicald eligible unpai										
	4, Medicaid HMO paid and eligible bu										
25.00	column 5, and other Medicaid days in			4.5	2				40		25 00
∠5.00	If this provider is an IRF, enter th Medicaid paid days in column 1, the		1	15	٥	0	0	•	48		25. 00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day										
	para and original abut dispute day	551 diiii1 5.	ı	1	ı	ı	I		ı	'	

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150011 Peri od: Worksheet S-2 From 07/01/2014 Part I 06/30/2015 Date/Time Prepared: 11/23/2015 7:14 am Program Name Program Code Unweighted IME Unwei ghted FTE 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 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, 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 and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions)
Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions)

N

Ratio (col. 1/

Unwei ghted

Unwei ghted

63.00

Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)

			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te			
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporti ng	
period that begins on or after J						
64.00 Enter in column 1, if line 63 is			0.00	0. 00	0. 000000	64. 00
in the base year period, the num						
resident FTEs attributable to ro						
settings. Enter in column 2 the						
resident FTEs that trained in yo						
of (column 1 divided by (column					5 () 6 (
	Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1. 00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63			0.00	0. 00	0. 000000	65.00
is yes, or your facility						
trained residents in the base						
year period, the program name						
associated with primary care						
FTEs for each primary care program in which you trained						
residents. Enter in column 2,						
the program code, enter in						
column 3, the number of						
unweighted primary care FTE						
residents attributable to						
rotations occurring in all						
non-provider settings. Enter in						
column 4. the number of						
unweighted primary care						
resident FTEs that trained in						
your hospital. Enter in column						
		I .	1		1	ı

5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

ealth Financial Systems IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	MARION GENER IDENTIFICATION DATA		CCN: 150011			u of Form CMS Worksheet S	
					7/01/2014 6/30/2015	Part I Date/Time P 11/23/2015	
					1. 00	2.00	
All Providers					1.00	2.00	
40.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the I	' for no in column 1. I	f yes, and home	office cos		N		140. (
1.00		00	1 110 11		3. 00		
If this facility is part of a chain home office and enter the home office				e name and	address	of the	
11. 00 Name:	Contractor's Name:	CONTRACTOR HAMBE		ctor's Nu	mber:		141.
12.00 Street:	PO Box:						142.
13. 00 Ci ty:	State:		Zi p Co	de:			143.
						1.00	
14.00 Are provider based physicians' costs	s included in Worksheet	A?				Υ	144.
					4 00	0.00	
45.00 f costs for renal services are clai	med on Wkst A line 7	1 are the costs	for		1. 00 N	2.00	145. (
inpatient services only? Enter "Y" no, does the dialysis facility incluperiod? Enter "Y" for yes or "N" for	for yes or "N" for no i ude Medicare utilizatio	n column 1. If c	column 1 is	5	IV		145.
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in o yes, enter the approval date (mm/dd.	changed from the previously column 1. (See CMS Pub.	,	•	lf	N		146.
Путот отто пред от по пред от по	77777						
7 00 Was there a shange in the statistic	al basica Entan "V" for	voo on "N" fon	20			1.00	147
7.00 Was there a change in the statistica 8.00 Was there a change in the order of a						N N	147. 148.
9.00 Was there a change to the simplified				or no.		N	149.
		Part A	Part E	3 T	itle V	Title XIX	
Does this facility contain a provide	or that qualifies for a	1.00	2.00	cation of	3. 00	4.00	
or charges? Enter "Y" for yes or "N							
5.00 Hospi tal		N	N		N	N	155.
6.00 Subprovider - IPF		N	N N		N	N	156. 157.
7.00 Subprovi der - I RF 8.00 SUBPROVI DER		N	IN IN		N	N	158.
9. 00 SNF		N	N		N	N	159.
O.OOHOME HEALTH AGENCY		N	N		N	N	160.
1. 00 CMHC			N		N	N	161.
						1.00	
Mul ti campus							
5.00 Is this hospital part of a Multicamp	ous hospital that has o	ne or more campu	ıses in dif	ferent CE	SSAs?	N	165.
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
6.00 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.	00 166.
						1.00	
Health Information Technology (HIT)				ment Act			
7.00 s this provider a meaningful user of 8.00 lf this provider is a CAH (line 105 reasonable cost incurred for the HI	is "Y") and is a meani	ngful user (line		"), enter	the	Y	167. 0168.
8.01 If this provider is a CAH and is no	t a meaningful user, do	es this provider			lshi p		168.
exception under §413.70(a)(6)(ii)? I					enter the	0.	75169.
69.00 If this provider is a meaningful use				Ве	gi nni ng	Endi ng	
69.00 If this provider is a meaningful use	5)				gi nni ng 1. 00 '01/2014	Endi ng 2. 00 09/30/2014	170.

7						2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCN:	150011	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Pre	
					11/23/2015 7:	14 am_
					1. 00	
171.00 If line 167 is "Y", does this prov	N	171. 00				
Medicare cost plans reported on Wk (see instructions)						

the other adjustments:

made to PS&R Report data for Other? Describe

21. 00	Was the cost report prepared only using the		N		N	21. 00		
	provider's records? If yes, see							
	instructions.							
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT CHILDRENS H	OSPI TALS)		1.00			
	Capital Related Cost							
22.00	Have assets been relifed for Medicare purpose	es? If yes, see instructions				22. 00		
	Have changes occurred in the Medicare deprec		als made durin	g the cost		23. 00		
	reporting period? If yes, see instructions.							
24.00	Were new leases and/or amendments to existing	g leases entered into during	this cost repo	rting period?		24. 00		
	If yes, see instructions							
25. 00	Have there been new capitalized leases entere	ed into during the cost repor	ting period? I	f yes, see		25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acqu	voc coo		26, 00				
20.00	instructions.	yes, see		20.00				
27. 00	Has the provider's capitalization policy char	naed durina the cost reportin	a period? If v	es. submit		27. 00		
	copy.		5 1					
	Interest Expense							
28. 00	Were new Loans, mortgage agreements or Lette	rs of credit entered into dur	ing the cost r	eporti ng		28. 00		
	period? If yes, see instructions.							
29. 00	Did the provider have a funded depreciation a	erve Fund)		29. 00				
00.00	treated as a funded depreciation account? If		111016			00.00		
30. 00	Has existing debt been replaced prior to its instructions.	scheduled maturity with new	debt? IT yes,	see		30. 00		
31. 00	Has debt been recalled before scheduled matur	rity without issuance of new	debt? If ves.	see		31. 00		
	instructions.							
	Purchased Services							
32.00	Have changes or new agreements occurred in pa	atient care services furnishe	d through cont	ractual		32. 00		
	arrangements with suppliers of services? If							
33. 00	If line 32 is yes, were the requirements of	Sec. 2135.2 applied pertainin	g to competiti	ve bidding? If		33. 00		
	no, see instructions.							
	Provi der-Based Physi ci ans							
34.00	Are services furnished at the provider facil	ity under an arrangement with	provi der-base	d physicians?		34. 00		
25 00	If yes, see instructions. If line 34 is yes, were there new agreements	or amonded evicting agreemen	to with the nr	ovi don bacad		35. 00		
33.00	physicians during the cost reporting period?		is with the pr	ovi dei -based		35.00		
	physicians during the cost reporting perrous	Tr yes, see mistructions.		Y/N	Date			
				1, 00	2.00			
	Home Office Costs				2.00			
36.00	Were home office costs claimed on the cost re	eport?				36. 00		
	If line 36 is yes, has a home office cost sta		home office?			37. 00		
	If yes, see instructions.							
38. 00	If line 36 is yes , was the fiscal year end (38. 00		
	the provider? If yes, enter in column 2 the					39. 00		
39.00	0 If line 36 is yes, did the provider render services to other chain components? If yes,							

	Home Office Costs						
36.00	Were home office costs claimed on the cost report?			36. 00			
37.00	If line 36 is yes, has a home office cost statement been pr	repared by the home office?		37. 00			
	If yes, see instructions.						
38.00	If line 36 is yes , was the fiscal year end of the home of	fice different from that of		38. 00			
	the provider? If yes, enter in column 2 the fiscal year end						
39. 00	If line 36 is yes, did the provider render services to other	er chain components? If yes,		39. 00			
	see instructions.						
40.00	.00 If line 36 is yes, did the provider render services to the home office? If yes, see						
	i nstructi ons.			<u> </u>			
		1. 00	2. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	TI NA	SEVERS	41.00			
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report	BLUE & CO., LLC		42.00			

41.00	Enter the first name, last name and the title/position	TI NA	SEVERS	41.00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42.00	Enter the employer/company name of the cost report	BLUE & CO., LLC		42.00
	preparer.			
43.00	Enter the telephone number and email address of the cost	317-713-7946	TSEVERS@BLUEANDCO. COM	43.00
	report preparer in columns 1 and 2, respectively.			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150011 Peri od: Worksheet S-2 From 07/01/2014 To 06/30/2015 Part II Date/Time Prepared: 11/23/2015 7:14 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 10/14/2015 17.00 Report for 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 report preparer in columns 1 and 2, respectively.

 Heal th Financial
 Systems
 MARION

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 150011

| Peri od: | Worksheet S-3 | From 07/01/2014 | Part | To 06/30/2015 | Date/Time Prepared: |

						10 06/30/2015	11/23/2015 7:	
							I/P Days / 0/P	i i diii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35pariarit	Line Number		o. Bodo	Avai I abl e	57.11 1.10 u .1 5		
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		78		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						l ol	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			78	28, 470	0.00		7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		19	6, 93	0.00	0	8. 00
9.00	CORONARY CARE UNIT				·			9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					o	13. 00
14. 00	Total (see instructions)	10.00		97	35, 40	0.00		14. 00
15. 00	CAH visits			**	00, 10	0.00	l o	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		0	1		l o	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		18		-	l o	17. 00
18. 00	SUBPROVI DER	42. 00		.0	0,0,		0	18. 00
19. 00	SKILLED NURSING FACILITY	12.00		Ŭ.				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	00.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			115				27. 00
28. 00	Observation Bed Days			113			0	28. 00
29. 00	1							29.00
30.00	Employee discount days (see instruction)							30.00
31. 00								31.00
32. 00	Labor & delivery days (see instructions)			0				32.00
32. 00	Total ancillary labor & delivery room			U		1		32.00
32.01	outpatient days (see instructions)							32.01
33 00	LTCH non-covered days							33. 00
55.00	12101 Holl covered days		ı	ı	I	T	I	1 33.00

| Peri od: | Worksheet S-3 | From 07/01/2014 | Part | To 06/30/2015 | Date/Time Prepared: |

				1	0 06/30/2015	11/23/2015 7:	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	6, 834	1, 549				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, 178	3, 225				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4. 00	HMO IRF Subprovider	131	51				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	_			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	·			6. 00
7. 00	Total Adults and Peds. (exclude observation	6, 834	1, 549	14, 339			7. 00
0.00	beds) (see instructions)	4 500		0 700			0.00
8.00	INTENSIVE CARE UNIT	1, 588	0	3, 722			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY		0	1, 945			12. 00 13. 00
14. 00	Total (see instructions)	8, 422	0 1, 549			772. 04	
15. 00	CAH visits	0, 422	1, 549	20,000	0.00	772.04	15. 00
16. 00	SUBPROVI DER - I PF	0	0	_	0.00	0.00	
17. 00	SUBPROVI DER - I RF	2, 646	115		0.00		•
18. 00	SUBPROVI DER	2,040	0	3, 240	0.00		
19. 00	SKILLED NURSING FACILITY		J		0.00	0.00	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)	o	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	791. 90	27. 00
28. 00	Observation Bed Days		1, 110	3, 259			28. 00
29. 00	Ambul ance Tri ps	1, 449					29. 00
30.00	Employee discount days (see instruction)			233			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	0				32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)	_					
33. 00	LTCH non-covered days	0		I		1	33. 00

				T	06/30/2015	Date/Time Prep 11/23/2015 7:	
		Full Time Equivalents		Di sch	arges	1172072010 71	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		С	1, 990	397	4, 998	1. 00
2.00	HMO and other (see instructions)			490	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	1, 990	397	4, 998	
15. 00	CAH visits		_	_	_	_	15. 00
16.00	SUBPROVI DER - I PF	0.00	0	_	0	0	16.00
17. 00	SUBPROVIDER - I RF	0.00	0	234	5	290	17. 00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY	0. 00	0	ų	U	0	18. 00 19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)						31. 00 32. 00
32. 00	Total ancillary labor & delivery room						32.00
32.01	outpatient days (see instructions)						32.01
33. 00	,						33. 00

Part						T	o 06/30/2015	Date/Time Pre 11/23/2015 7:	
Note								Average Hourly	
March 1 - MGE_BATA			Line Number	Reported				,	
SAM JABET 1					,			COI . 3)	
1.00 Inchi asil aries (see 200.00 49,327,742 -1-99,915 49,127,827 7,925,129.00 25,522 1.00 Inchi asil aries (see 200.00 49,327,742 -1-99,915 49,127,827 7,925,129.00 25,522 1.00 Inchi asil aries (see 200.00 49,327,742 -1-99,915 49,127,827 7,925,129.00 2.5,522 1.00 2			1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
Total sati arises (see 200.00 49.321,742 -199.916 49.121,827 1,925.129.00 25.02 1.00									-
2.00 Amp-physic clain anestheritist Part 0 0 0 0 0 0 0 0 0	1.00		200. 00	49, 321, 742	-199, 915	49, 121, 827	1, 925, 129. 00	25. 52	1.00
3.00 Non-physician anesthetist Part 4.00 Non-physician anesthetist Part 4.01 Physician-Part A - 4.01 Physicians - Part A - Teaching 4.01 Physicians - Part A - Teaching 5.00 Physicians - Part A - Teaching 6.00 Non-physician-Part II 6.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	1		0			0.00	0.00	2 00
4. 00 Physician-Part A - 4. Min instrative provided in the provided program of	2.00			Ü	0	0	0.00	0.00	2.00
4.00 Physician-Part A	3.00			0	0	0	0.00	0. 00	3. 00
4.01 Physicians - Part & - Toaching 0 0 0 0 0 0 0 0 0	4. 00	Physician-Part A -		37, 698	О	37, 698	251.00	150. 19	4. 00
5.00 Physician-Part B	4 01			0	0	0	0.00	0.00	4 01
Interms & residents (in an approved program)				Ö	ő	ő		l .	
approved program approved program approved presidents (in an approved presidents) approved presidents (in approved presidents) approved presidents (in approved pres			21 00	0	0	0		l .	
Residents (in an approved programs)	7.00		21.00	Ü	0	0	0.00	0.00	7.00
8. 00 More office personnel 44,00 0 0 0 0 0 0 0 0 0	7. 01			0	0	0	0.00	0. 00	7. 01
SNE		` ''							
10.00 Excluded area salaries (see 6.774.511 1.006.936 7.781.447 404.473.00 19.24 10.00				0	0	0			
Instructions)			44.00	0 6 774 511	1 006 936	0 7 781 447			1
11.00 Contract Labor: Direct Patient	. 0. 00	instructions)		5,771,511	1,000,700	1,101,111	101, 170.00	.,,,,]
Care	11 00			EE4 240	1 0	556 260	7 622 00	72.00	11 00
management and other management management and other management and other management manageme	11.00			550, 500		330, 308	7, 022. 00	73.00	11.00
management and admin is strative services 207,900 0 207,900 1,242.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 14.00 167.39 13.00 15.00 167.39 13.00 167.39 13.00 167.39 13.00 167.39 13.00 15.00	12.00			0	0	0	0.00	0. 00	12. 00
13.00 Contract labor: Physician-Part 207,900 0 207,900 1,242.00 167.39 13.00 14.00 1									
A - Admin istrative	40.00	•		007.000		007.000		447.00	
Wage-related costs	13.00			207, 900	0	207, 900	1, 242. 00	167. 39	13.00
15.00	14. 00			0	0	0	0.00	0. 00	14. 00
16.00 Home office and Contract Physicians Part A - Teaching	15. 00			0	0	0	0.00	0.00	15. 00
Physic clans Part A - Teaching	17 00			0			0.00	0.00	14 00
17. 00 Wage-related costs (core) (see	10.00	Physicians Part A - Teaching					0.00	0.00	10.00
18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00 18. 00 19. 00 1	17. 00			13, 557, 706	0	13, 557, 706] 17. 00
See instructions Secular and a season Secular and a sec	40.00	instructions)							10.00
19. 00 Éxcl uded areas 3,818,820 0 3,818,820 20. 00 0 0 0 0 0 0 0 0	18.00			0	0	0			18.00
21.00 Non-physician anesthetist Part B		Excluded areas		3, 818, 820	0	3, 818, 820			19. 00
22.00 Physician Part A -	20. 00	Non-physician anesthetist Part		0	0	0			20.00
Administrative	21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 01 Physician Part A - Teaching 0 0 0 0 23. 00	22. 00			1, 770	О	1, 770			22. 00
23.00 Physician Part B 0 0 0 0 24.00 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0	22 01			0	_	0			22 01
25.00				-	1	ő			23. 00
approved program OVERHEAD COSTS - DIRECT SALARIES				-	0	0			24.00
26.00 Employee Benefits Department	25.00	approved program)			0	0			25.00
27. 00 Administrative & General 5. 00 11, 184, 579 -2, 781, 394 8, 403, 185 311, 634. 00 26. 96 27. 00 28. 00 Administrative & General under contract (see inst.) 3, 356, 462 0 3, 356, 462 16, 097. 00 208. 51 28. 00 29. 00 Maintenance & Repairs 6. 00 0 0 0 0. 00 0. 00 0. 00 29. 00 30. 00 Operation of Plant 7. 00 477, 447 19, 145 496, 592 29, 137. 00 17. 04 30. 00 17. 04 30. 00 0 0 0. 00<	24 00			042 022	00.070	041 002	29 020 00	22 54	34 00
28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0 0 0 0 0 0 0 0 0									
29. 00 Maintenance & Repairs 6. 00 0 0 0 0.00 0.00 0.00 29. 00 30. 00 Operation of Plant 7. 00 477, 447 19, 145 496, 592 29, 137. 00 17. 04 30. 00 31. 00 Laundry & Linen Service 8. 00 0 0 0 0.00 0.00 0.00 31. 00 32. 00 Housekeeping 9. 00 0 0 0 0.00 0.00 0.00 32. 00 33. 00 Housekeeping under contract (see instructions) 1, 503, 768 0 1, 503, 768 106, 160. 00 14. 17 33. 00 34. 00 Di etary 10. 00 0 0 0 0.0	28. 00			3, 356, 462	0	3, 356, 462	16, 097. 00	208. 51	28. 00
30. 00 Operation of Plant 7. 00 477, 447 19, 145 496, 592 29, 137. 00 17. 04 30. 00 31. 00 31. 00 32. 00 Housekeeping 9. 00 0 0 0 0 0 0 0 0 0	29 00		6 00	0	0	0	0.00	0.00	29 00
32. 00 Housekeeping		Operation of Plant		477, 447	19, 145	496, 592		17. 04	30.00
33.00 Housekeeping under contract (see instructions) 34.00 Di etary Di etary under contract (see instructions) 36.00 Cafeteria Cafeteria Di under contract (see instructions) 10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0			1
(see instructions) 34.00 Di etary 35.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 39.00 Central Services and Supply 30.00 Central Services and Supply			9.00	0 1, 503, 768		1			1
35.00 Di etary under contract (see instructions) 36.00 Cafeteria 11.00 0 0 0 0 0.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 37.00 38.00 Nursing Administration 13.00 1,210,152 -399,475 3810,677 21,117.00 38.39 38.00 39.00 Central Services and Supply 14.00 131,444 32,761 164,205 8,959.00 1,277,677 62,581.00 20.42 35.00 36.00 37.00 38.00 38.00 39.00 39.00 1,277,677 0 0 0.00 0 0.00 0 0.00 0 0.00 37.00 38.39 38.00 38.39 38.00		(see instructions)	40.00						
instructions) 36.00 Cafeteria			10. 00	0 1, 277, 677	0	0 1, 277, 677		1	1
37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,210,152 -399,475 810,677 21,117.00 38.39 38.00 39.00 Central Services and Supply 14.00 131,444 32,761 164,205 8,959.00 18.33 39.00		instructions)		-	_	_			
38.00 Nursing Administration 13.00 1,210,152 -399,475 810,677 21,117.00 38.39 38.00 Central Services and Supply 14.00 131,444 32,761 164,205 8,959.00 18.33 39.00		1		0	0	0		l .	
	38. 00	Nursing Administration	13. 00				21, 117. 00	38. 39	38. 00
									1
		i nar macy	15.00	2, 203, 070	1 00,010	2, 331, 700		1 42.00	70.00

Heal th	Financial Systems		MARION GENER	RAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI 7	TAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
						From 07/01/2014		
						To 06/30/2015		
							11/23/2015 7:	<u>14 am</u>
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5. 00	6. 00	
41.00	Medical Records & Medical	16. 00	(0 0		0.00	0.00	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	(0 0		0.00	0.00	42. 00
43. 00	Other General Service	18. 00	(0 (c		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 150011 Peri od: Worksheet S-3 From 07/01/2014 To 06/30/2015 Part III Date/Time Prepared: 11/23/2015 7:14 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 . col. 5) Salaries in (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 55, 459, 649 -199, 915 55, 259, 734 2, 109, 967. 00 1.00 26. 19 instructions) 2.00 6, 774, 511 7, 781, 447 404, 473. 00 19. 24 2.00 Excluded area salaries (see 1,006,936 instructions) 3.00 Subtotal salaries (line 1 48, 685, 138 -1, 206, 851 47, 478, 287 1, 705, 494. 00 27.84 3.00 minus line 2) 4.00 Subtotal other wages & related 764, 268 764, 268 8, 864.00 86. 22 4.00 costs (see inst.) Subtotal wage-related costs 5.00 13, 559, 476 C 13, 559, 476 0.00 28. 56 5.00 (see inst.) Total (sum of lines 3 thru 5) 63, 008, 882 6.00 6.00 -1, 206, 851 61, 802, 031 1, 714, 358. 00 36. 05

-2, 943, 083

19, 306, 375

640, 531. 00

30.14

7.00

22, 249, 458

7.00

Total overhead cost (see

instructions)

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150011	
		From 07/01/2014 Part IV

PART IV - WAGE RELATED COSTS Fart A - Core List RETITEMENT COST		To 06/30/2015	Date/Time Pre 11/23/2015 7:	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Empl oyer Contributions 1,057,333 1.00 401K Empl oyer Contributions 2.00 400K Empl oyer Contributions 2.00 4.00			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00 Tax Sheltered Annuity (TSA) Employer Contribution 0 0 0 0 0 0 0 0 0		RETI REMENT COST		
3.00 Nonqual if ied Defined Benefit Plan Cost (see instructions) 2, 204, 914 3.00 0 4.00 0 2.004 3.00 0 4.00 0 2.004 3.00 2.004 3.00 2.004 3.00 2.000	1.00		1, 057, 333	1.00
A. 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration Fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 131, 237 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 The Plan Administration Fees	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2, 204, 914	3. 00
5.00	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
131, 237 6.00 131, 237 131, 237 6.00 131, 237 131, 2				
The color of the	5.00		_	
HEALTH AND INSURANCE COST	6.00		131, 237	6. 00
Real th Insurance (Purchased or Self Funded) 8, 381, 208 8. 00 9. 00 10. 0	7.00		0	7. 00
Prescription Drug Plan 0 9.00				
10.00 Dental, Hearing and Vision Plan 994 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 40,149 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 40,149 11.00 13.00 Disability Insurance (If employee is owner or beneficiary) 489,561 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 516,036 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion 16.00 Non cumulative portion Only 4,121,467 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 30,213 19.00 20.00 OTHER 21.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 10.00 Inistructions) 22.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 311,451 23.00 24.00 Part B - Other than Core Related Cost 40.00 24.00 Part B - Other than Core Related Cost 40.00 25.00 25.00 25.00 26.00 26.00 27.00 27.00 27.00 27.00 28.00 28.00 28.00 29.00 29			8, 381, 208	
11.00 Life Insurance (If employee is owner or beneficiary) 40,149 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 489,561 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 516,036 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 4,121,467 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 30,213 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 19.00 Line (If employee is owner or beneficiary) 0 18.00 19.00 Unemployment Insurance 0 21.00 21.00 Instructions 0 22.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 311,451 23.00 24.00 Part B - Other than Core Related Cost 40.00 24.00 Part B - Other than Core Related Cost 40.00 24.00 Part B - Other than Core Related Cost 20.00 25.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 27.00 27.00 27.00 28.00 28.00 29.00 29.00 29.00 29.00	9.00			
12.00	10.00	Dental, Hearing and Vision Plan	994	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) Norkers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumul ative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	11. 00		40, 149	
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Tuit ion Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00			
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 4, 121, 467 17.00 Medicare Taxes - Employers Portion Only 0 18.00 Unemployment Insurance 30, 213 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 instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuit ion Reimbursement 311, 451 23.00 Total Wage Related cost (Sum of Lines 1 -23) 17, 284, 563 24.00 Part B - Other than Core Related Cost	13.00		489, 561	
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 10.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				
Non cumulative portion TAXES TICA-Employers Portion Only 17.00 18.00 Medicare Taxes - Employers Portion Only 0			516, 036	
TAXES 17. 00 FI CA-Employers Portion Only 4, 121, 467 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 30, 213 19. 00 20. 00 0 0 0 0 0 0 0 0	16.00		0	16. 00
17. 00 FI CA-Employers Portion Only 4, 121, 467 17. 00 18. 00 19. 00 1				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 30,213 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 instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 311,451 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17,284,563 24.00 Part B - Other than Core Related Cost				
19. 00 Unempl oyment Insurance 30, 213 19. 00 20. 00 State or Federal Unempl oyment Taxes 0 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21. 00 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuit ion Reimbursement 311, 451 23. 00 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 17, 284, 563 24. 00 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 0 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 311, 451 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 17, 284, 563 24.00 Part B - Other than Core Related Cost				
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21. 00 Total Wage Related Cost 17, 284, 563 24. 00				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20. 00		0	20. 00
instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost		·		
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 311, 451 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 17, 284, 563 24. 00 Part B - Other than Core Related Cost	21. 00		0	21. 00
23. 00 Tuition Reimbursement 311, 451 23. 00 24. 00 Part B - Other than Core Related Cost (Sum of lines 1 -23) 24. 00				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24.00				
Part B - Other than Core Related Cost				
	24. 00		17, 284, 563	24. 00
25. 00 EMPLOYEE RELATIONS 93, 734 25. 00	0= 6-		00 ==-	05.05
	25. 00	EMPLOYEE RELATIONS	93, 734	25.00

Health Financial Systems MAF	RION GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150011	From 07/01/2014	Worksheet S-3 Part V Date/Time Pre 11/23/2015 7:	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identificat	i on:]

	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	0	0	1.00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17.00	Renal Dialysis			17. 00
18. 00	0ther	0	0	18. 00

HOSPI.	Financial Systems MARION GENERAL HOSPI				u of Form CMS-2	
	FAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN		Period: From 07/01/2014	Worksheet S-10	0
				To 06/30/2015	Date/Time Pre	pared:
					11/23/2015 7:	
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line :	202 column	8)	0. 327504	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				12, 384, 750	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental page 1.		m Medicaid	?		4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Me	edi cai d			0	5.00
6.00	Medi cai d charges				52, 082, 458	
7.00	Medicaid cost (line 1 times line 6)	- •	6.1.	0 15 16	17, 057, 213	
8.00	Difference between net revenue and costs for Medicaid program (lin < zero then enter zero)	ne / minus s	sum or lin	es 2 and 5; IT	4, 672, 463	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction:	ns for each	line)			
9. 00	Net revenue from stand-alone SCHIP	is for cacif	TTHE		0	9. 00
10.00					0	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				o	
12.00	Difference between net revenue and costs for stand-alone SCHIP (li	ne 11 minus	s line 9;	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see instruc					
13.00	Net revenue from state or local indigent care program (Not include					13.00
14. 00	Charges for patients covered under state or local indigent care pr	rogram (Not	i ncl uded	n lines 6 or	0	14.00
45.00	10)					45.00
15. 00 16. 00	State or local indigent care program cost (line 1 times line 14)	+	oarom (lin	a 15 minua lina	0	15. 00 16. 00
16.00	Difference between net revenue and costs for state or local indige 13; if < zero then enter zero)	ent care pro	ogram (III)	e is minus iine	U	16.00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fundi	ng charity	care		0	17. 00
18.00					0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local i	ndi gent ca	re program:	s (sum of lines	4, 672, 463	19. 00
	8, 12 and 16)	_				
			Jni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	Total initial obligation of patients approved for charity care (at	t full	1. 00 14, 985, 18	2. 00 1 38, 590, 604	3. 00 53, 575, 785	20.00
20 00			14, 700, 18	30, 390, 004	33, 373, 785	₁ ∠∪. ∪∪
20. 00	ICHARGES EXCLUDING NON-RELIMBURSABLE COST CENTERS) FOR THE ENTURE TO			1		
	charges excluding non-reimbursable cost centers) for the entire fa	(Line 1	4. 907. 70	7 12, 638, 577	17, 546, 284	21. 00
20. 00		(line 1	4, 907, 70	7 12, 638, 577	17, 546, 284	21. 00
	Cost of initial obligation of patients approved for charity care (times line 20)	(line 1	4, 907, 70 156, 64		17, 546, 284 13, 136, 529	
21. 00 22. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care	(line 1		12, 979, 889		22. 00
21. 00 22. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care	(line 1	156, 64	12, 979, 889	13, 136, 529	22. 00
21. 00 22. 00 23. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)		156, 64 4, 751, 06	12, 979, 889 7 -341, 312	13, 136, 529 4, 409, 755 1. 00	22. 00 23. 00
21. 00 22. 00 23. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da	ays beyond a	156, 64 4, 751, 06	12, 979, 889 7 -341, 312	13, 136, 529 4, 409, 755	22. 00 23. 00
21. 00 22. 00 23. 00 24. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro	ays beyond a	156, 64 4, 751, 06 a Length o	12,979,889 -341,312	13, 136, 529 4, 409, 755 1. 00 N	22. 00 23. 00 24. 00
21. 00 22. 00 23. 00 24. 00 25. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent	ays beyond apgram?	156, 64 4, 751, 06 a Length o	12,979,889 -341,312	13, 136, 529 4, 409, 755 1. 00 N	22. 00 23. 00 24. 00 25. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instru	ays beyond a ogram? care progra	156, 64 4, 751, 06 a Length o	12,979,889 -341,312	13, 136, 529 4, 409, 755 1. 00 N 0 12, 819, 675	22. 00 23. 00 24. 00 25. 00 26. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction)	ays beyond a ogram? care progra uctions)	156, 64 4, 751, 06 a Length o	12,979,889 -341,312	13, 136, 529 4, 409, 755 1. 00 N 0 12, 819, 675 672, 739	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction Non-Medicare and non-reimbursable Medicare bad debt expense (line	ays beyond a ogram? care progra uctions) ons) 26 minus li	156, 64 4, 751, 06 a Length o am's Length	12, 979, 889 -341, 312 f stay limit	13, 136, 529 4, 409, 755 1. 00 N 0 12, 819, 675 672, 739 12, 146, 936	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Cost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient da imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction Non-Medicare and non-reimbursable Medicare bad debt expense (line Cost of non-Medicare and non-reimbursable Medicare bad debt expense)	ays beyond a ogram? care progra uctions) ons) 26 minus li	156, 64 4, 751, 06 a Length o am's Length	12, 979, 889 -341, 312 f stay limit	13, 136, 529 4, 409, 755 1. 00 N 0 12, 819, 675 672, 739	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00

	FINANCIAL SYSTEMS	MARTUN GENERAL		CCN 150011 5		U OF FORM CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider		eriod: rom 07/01/2014	Worksheet A	
					o 06/30/2015	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	11/23/2015 7: Recl assi fi ed	14 am
	cost center bescriptron	Sal al Les	other	+ col . 2)	ons (See A-6)	Trial Balance	
					0.10 (000 /1 0)	(col . 3 +-	
						col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		40 (50 5(0	40 (50 5(6	4 044 070	44 447 007	1 4 00
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	842, 833	12, 658, 568 16, 929, 354	12, 658, 568 17, 772, 187		11, 447, 296 17, 922, 777	1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	11, 184, 579	18, 232, 646	29, 417, 225		26, 848, 947	5.00
6. 00	00600 MAINTENANCE & REPAIRS	0	0 0	27, 117, 220	0	0	6.00
6. 01	00601 CAFETERI A	0	0	C	1, 366, 143	1, 366, 143	6. 01
6.02	00602 CAFETERI A	0	0	C	0	0	6. 02
7. 00	00700 OPERATION OF PLANT	477, 447	4, 242, 839	4, 720, 286		5, 164, 828	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	432, 419	432, 419		432, 419	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY		2, 540, 920 1, 973, 479	2, 540, 920 1, 973, 479		2, 549, 872 554, 909	9. 00 10. 00
13. 00	01300 NURSING ADMINISTRATION	1, 210, 152	43, 425	1, 253, 577		854, 102	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	131, 444	341, 149			505, 354	14.00
15. 00	01500 PHARMACY	2, 265, 096	6, 406, 521	8, 671, 617		2, 760, 800	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	7, 994, 515	1, 219, 152	9, 213, 667		8, 816, 598	30.00
31. 00	03100 NTENSI VE CARE UNI T	2, 421, 603	319, 899	2, 741, 502	75, 606	2, 817, 108	31.00
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	1 000 050	014 024	1 000 007	20, 020	1 0/2 715	40.00
41. 00 42. 00	04200 SUBPROVI DER	1, 009, 050	814, 836	1, 823, 88 <i>6</i>	l I	1, 862, 715 0	41. 00 42. 00
43. 00	04300 NURSERY		0		ا ۱	1, 053, 485	43.00
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		1,000,100	1,000,100	10.00
50.00	05000 OPERATI NG ROOM	1, 613, 778	7, 499, 208	9, 112, 986	232, 032	9, 345, 018	50.00
51.00	05100 RECOVERY ROOM	0	0	C	o	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 903, 323	2, 779, 640	5, 682, 963		4, 927, 703	54.00
57. 00	05700 CT SCAN	0	0	C	873, 289	873, 289	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	522 270	1 7/0 /00	2 201 0/6	514, 940	514, 940	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	533, 278 2, 430, 770	1, 768, 690 4, 267, 892	2, 301, 968 6, 698, 662		2, 393, 258 6, 811, 202	59. 00 60. 00
60. 00	06001 ONCOLOGY	945, 312	4, 207, 692 547, 470	1, 492, 782	1	1, 569, 654	
60. 02	06002 RADIATION ONCOLOGY	743, 312	0	1, 472, 702	70, 072	1, 307, 034	60.02
65. 00	06500 RESPI RATORY THERAPY	1, 198, 798	683, 776	1, 882, 574	158, 304	2, 040, 878	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 568, 067	285, 599	1, 853, 666	76, 491	1, 930, 157	66.00
69. 00	06900 ELECTROCARDI OLOGY	631, 840	101, 269	733, 109		863, 814	69. 00
69. 01	06901 CARDI AC REHAB	98, 665	5, 324	103, 989	39, 190	143, 179	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		6, 002, 249	6, 002, 249	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	J 0			0,002,247	0, 002, 247	73.00
90.00	09000 CLI NI C	211, 240	91, 402	302, 642	82, 780	385, 422	90.00
91.00	09100 EMERGENCY	3, 884, 491	981, 443	4, 865, 934	143, 524	5, 009, 458	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C	0	0	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS	0/4 104	144 000	1 000 27/	117 101	1 105 4/7	05 00
95.00	O9500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	864, 194	144, 082	1, 008, 276	117, 191	1, 125, 467	95.00
113 00	11300 I NTEREST EXPENSE		0	(ol	0	113. 00
118. 00		44, 420, 475	85, 311, 002	129, 731, 477		128, 893, 041	
	NONREI MBURSABLE COST CENTERS			, , ,		.,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 456	14, 456	20, 886	35, 342	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0		192. 00
	19202 VISITOR MEALS	0	0	107.04	0		192. 02
192. 03					11, 844	149, 812	1192. 03
	19203 GREAT BEGINNINGS/MATERNAL	135, 275	2, 693	137, 968	, , ,	Ō	
192.04	19204 LI FELI NE	0	0	C	0		192. 04
192. 04 192. 05	19204 LIFELINE 19205 OWNED PROPERTIES	0	0 1, 070, 829	1, 070, 829	0 -738, 610	332, 219	192. 04 192. 05
192. 04 192. 05 192. 08	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING	1	0 1, 070, 829 19, 194	1, 070, 829 47, 380	0 -738, 610 17, 899	332, 219 65, 279	192. 04 192. 05 192. 08
192. 04 192. 05 192. 08 192. 09	19204 LIFELINE 19205 OWNED PROPERTIES	0 0 28, 186	0 1, 070, 829	1, 070, 829	0 -738, 610 17, 899 16, 492	332, 219 65, 279 5, 565	192. 04 192. 05 192. 08 192. 09
192. 04 192. 05 192. 08 192. 09 192. 10	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT	0 0 28, 186 0	0 1, 070, 829 19, 194 -10, 927	0 1, 070, 829 47, 380 -10, 927	0 -738, 610 17, 899 16, 492 0	332, 219 65, 279 5, 565	192. 04 192. 05 192. 08 192. 09 192. 10
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	0 0 28, 186 0 0 878, 582 379, 695	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	0 0 28, 186 0 0 878, 582 379, 695	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17
192. 04 192. 05 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811 185, 452	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543 539, 761	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354 725, 213	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484 46, 191	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838 771, 404	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 193. 00	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811 185, 452 0	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543 539, 761	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354 725, 213	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484 46, 191	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838 771, 404	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 18 192. 18 193. 00 193. 01	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811 185, 452	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543 539, 761	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354 725, 213	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484 46, 191 0 23, 123	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838 771, 404	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811 185, 452 0 244, 263	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543 539, 761 0 608, 517	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354 725, 213 0 852, 780	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484 46, 191 0 23, 123 18, 818	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838 771, 404 0 875, 903	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01 193. 02
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 193. 00 193. 01 193. 03 193. 04	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811 185, 452 0 244, 263 145, 106 0 678, 644	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543 539, 761 0 608, 517 527, 211 2, 678, 358 1, 470, 663	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354 725, 213 0 852, 780 672, 317 2, 678, 358 2, 149, 307	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484 46, 191 0 23, 123 18, 818 64, 046 49, 522	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838 771, 404 0 875, 903 691, 135 2, 742, 404 2, 198, 829	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 193. 00 193. 01 193. 03 193. 03
192. 04 192. 05 192. 06 192. 10 192. 10 192. 14 192. 15 192. 17 193. 00 193. 01 193. 02 193. 04 193. 04 193. 05	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC NORTHWOOD 19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT 19305 MGH FMC SWAYZEE	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811 185, 452 0 244, 263 145, 106 0 678, 644 62, 640	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543 539, 761 0 608, 517 527, 211 2, 678, 358 1, 470, 663 115, 951	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354 725, 213 0 852, 780 672, 317 2, 678, 358 2, 149, 307 178, 591	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484 46, 191 0 23, 123 18, 818 64, 046 49, 522 32, 983	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838 771, 404 0 875, 903 691, 135 2, 742, 404 2, 198, 829 211, 574	192. 04 192. 05 192. 08 192. 09 192. 10 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01 193. 02 193. 04 193. 05
192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 193. 00 193. 01 193. 03 193. 04 193. 05 193. 05	19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	0 0 28, 186 0 0 878, 582 379, 695 0 584, 728 58, 811 185, 452 0 244, 263 145, 106 0 678, 644	0 1, 070, 829 19, 194 -10, 927 0 418, 257 1, 824, 411 1, 015, 163 1, 704, 507 250, 543 539, 761 0 608, 517 527, 211 2, 678, 358 1, 470, 663	1, 070, 829 47, 380 -10, 927 0 1, 296, 839 2, 204, 106 1, 015, 163 2, 289, 235 309, 354 725, 213 0 852, 780 672, 317 2, 678, 358 2, 149, 307 178, 591 1, 224, 726	0 -738, 610 17, 899 16, 492 0 169, 195 104, 245 0 472, 845 4, 484 46, 191 0 23, 123 18, 818 64, 046 49, 522 32, 983 83, 195	332, 219 65, 279 5, 565 0 1, 466, 034 2, 308, 351 1, 015, 163 2, 762, 080 313, 838 771, 404 0 875, 903 691, 135 2, 742, 404 2, 198, 829	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 193. 00 193. 01 193. 02 193. 03 193. 04 193. 05 193. 06

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 07/01/2014	Worksheet A	
				Γο 06/30/2015		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
193.08 19308 MGH FMC CONVERSE	102, 684	178, 569	281, 25	12, 327	293, 580	193. 08
193.09 19309 MGH UPLAND HEALTH	331, 830	962, 072	1, 293, 90	33, 917	1, 327, 819	193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0		0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	48, 369	205, 095	253, 46	12, 953	266, 417	193. 11
193. 12 19312 OB/GYN	394, 461	1, 921, 684	2, 316, 14	41, 112	2, 357, 257	193. 12
193. 15 19315 MGH RIVER VIEW BLDG	0	0		0	0	193. 15
194.00 07963 OTHER NONREI MBURSABLE	O	0		0	0	194. 00
194. 01 07950 MOW	O	0		0	0	194. 01
194. 02 07951 MENTAL HEALTH	O	0		0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0		206, 721	206, 721	194. 03
194. 04 07953 MGH WORK SOLUTIONS	297, 812	480, 849	778, 66	81, 261	859, 922	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	42, 286	100, 320	142, 60	6, 535	149, 141	194. 05
194.08 07957 MGH SMMP BLDG	0	274, 017	274, 01	7 0	274, 017	194. 08
194.09 07958 MGH AMBUCARE BLDG	o	62, 490	62, 490	0	62, 490	194. 09
194. 10 07959 MGH 106 LYONS BLDG	0	6, 014	6, 01	4 0	6, 014	194. 10
200.00 TOTAL (SUM OF LINES 118-199)	49, 321, 742	103, 005, 889	152, 327, 63°	1 0	152, 327, 631	200. 00

Peri od: From 07/01/2014 To 06/30/2015 Worksheet A Date/Time Prepared: 11/23/2015 7: 14 am

Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00	
0.00 7.00	
GENERAL SERVICE COST CENTERS	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT -207, 516 11, 239, 780	1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 7,858,243 25,781,020	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL -6, 564, 303 20, 284, 644	5. 00
6. 00 00600 MAI NTENANCE & REPAI RS 0 0	6. 00
6. 01 00601 CAFETERI A -23, 896 1, 342, 247	6. 01
6. 02 00602 CAFETERI A 0 0	6. 02
7. 00 00700 0PERATI ON OF PLANT -168, 011 4, 996, 817 4, 917 4,	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE -6, 867 425, 552	8. 00 9. 00
9. 00 00900 HOUSEKEEPI NG	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON -61 854, 041	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY -625 504, 729	14. 00
15. 00 01500 PHARMACY	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS -27, 721 8, 788, 877	30. 00
31. 00 03100 I NTENSI VE CARE UNI T -616 2, 816, 492	31. 00
40. 00 04000 SUBPROVI DER - 1 PF 0 0	40. 00
41. 00 04100 SUBPROVI DER - RF -77, 027 1, 785, 688	41.00
42. 00 04200 SUBPROVI DER	42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	43.00
50. 00 05000 0PERATI NG ROOM -25, 477 9, 319, 541	50. 00
51. 00 05100 RECOVERY ROOM 0 0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C -167, 986 4, 759, 717	54.00
57. 00 05700 CT SCAN 0 873, 289	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 514, 940	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON -7, 355 2, 385, 903	59. 00
60. 00 06000 LABORATORY	60.00
60. 01 06001 0NC0L0GY	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	60. 02 65. 00
66. 00 06600 PHYSI CAL THERAPY	66. 00
69. 00 06900 ELECTROCARDI OLOGY	69. 00
69. 01 06901 CARDI AC REHAB	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS -2, 400 5, 999, 849	73. 00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINI C -237 385, 185	90.00
91. 00 09100 EMERGENCY -166, 584 4, 842, 874 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	91. 00 92. 00
92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART)	92. 01
OTHER REIMBURSABLE COST CENTERS	72.01
95. 00	95. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE 0 0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) 146, 364 129, 039, 405	118. 00
NORREI MBURSABLE COST CENTERS	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 35, 342 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0	190. 00 192. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 02 19202 VI SI TOR MEALS 0 0	192. 00
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 0 149, 812	192. 03
192. 04 19204 LI FELI NE 0 0	192. 04
192. 05 19205 OWNED PROPERTIES 0 332, 219	192. 05
192. 08 19211 PARISH NURSING 0 65, 279	192. 08
192. 09 19212 BIOTERRORI SM GRANT 0 5, 565	192. 09
192. 10 19214 BREAST PUMPS 0 0	192. 10
192. 14 19210 MGH PHYS PRACT MGMT -63, 467 1, 402, 567	192. 14
192. 15 19215 MGH MARI ON SURGEONS -76, 658 2, 231, 693	192. 15
192. 16 19216 MGH MGH MED ONC 0 1, 015, 163	192. 16 192. 17
192. 17 19217 MGH FMC SOUTH -320, 299 2, 441, 781 192. 18 19218 MGH FAI RM MED ASSOC 0 313, 838	192. 17
192. 10 192.10 WIGH FALKW WED ASSOC 519, 836 192. 19 192.19 MGH FMC MARION -59, 975 711, 429	192. 16
193. 00 19300 NONPALD WORKERS 0 0	193. 00
193. 01 19301 MGH FMC NORTHWOOD 0 875, 903	193. 01
193. 02 19302 MGH FMC GAS CITY 0 691, 135	193. 02
193. 03 19303 MGH HOSPI TALI STS 0 2, 742, 404	193. 03
193. 04 19304 MGH MAR FAM PRACT 0 2, 198, 829	193. 04
193. 05 19305 MGH FMC SWAYZEE -28, 735 182, 839	193. 05
193. 06 19306 MGH PEDI ATRI C CTR -80, 622 1, 227, 299	193. 06
193. 07 19307 MGH SPECI ALTY PHYS -42, 145 336, 214 193. 08 19308 MGH FMC CONVERSE 0 293, 580	193. 07 193. 08
193. 08 19308 MGH UPLAND HEALTH 0 1, 327, 819	193. 08
,	1175.07

 Health Financial
 Systems
 MARION GE

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 150011

Peri od: Worksheet A From 07/01/2014 O6/30/2015 Date/Time Prepared: 11/23/2015 7:14 am

			11/23/2015 7:14 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7. 00	
193. 10 19310 MGH MGH WOMENS CTR	0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	-9, 521	256, 896	193. 11
193. 12 19312 OB/GYN	0	2, 357, 257	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	194. 00
194. 01 07950 MOW	0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	206, 721	194. 03
194.04 07953 MGH WORK SOLUTIONS	-103, 522	756, 400	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	149, 141	194. 05
194.08 07957 MGH SMMP BLDG	0	274, 017	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	62, 490	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	6, 014	194. 10
200.00 TOTAL (SUM OF LINES 118-199)	-638, 580	151, 689, 051	200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2014 To 06/30/2015 Date/Time Prepared: Provider CCN: 150011

					'23/2015 7:14 am
		Increases			
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	
	A - SATELLITE OFFICE RECLASS		2 2/2		4.00
1.00	ELECTROCARDI OLOGY	69.00	9, 263	4, 042	1.00
2. 00	RADI OLOGY-DI AGNOSTI C	5400	9 <u>6, 2</u> 70	2 <u>5, 5</u> 56	2. 00
	TOTALS		105, 533	29, 598	
1. 00	B - CAFETERIA RECLASS ADMINISTRATIVE & GENERAL	5. 00	ol	01 124	1.00
2. 00	CAFETERIA	6. 01	0	81, 124 1, 366, 143	1.00
2.00	TOTALS			1, 447, 267	2.00
	C - ADMIN DIRECTOR RECLASS		UU	1,447,207	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	44, 372	0	1.00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	24, 129	Ö	2. 00
3.00	ADULTS & PEDIATRICS	30.00	231, 794	0	3. 00
4. 00	OPERATING ROOM	50.00	45, 164	0	4. 00
5. 00	CARDI AC CATHETERI ZATI ON	59.00	62, 825	0	5. 00
6.00	RESPIRATORY THERAPY	65.00	103, 234	O	6. 00
7.00	ELECTROCARDI OLOGY	69. 00	65, 049	0	7. 00
8.00	CARDI AC REHAB	69. 01	18, 848	0	8. 00
9.00	CLINIC	90.00	34, 411	0	9. 00
11.00	AMBULANCE SERVICES	95. 00	48, 250	0	11. 00
12.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	20, 886	0	12. 00
	CANTEEN				
13.00	GREAT BEGINNINGS/MATERNAL	192. 03	6, 990	0	13. 00
14. 00	PARI SH NURSI NG	192. 08	11, 757	0	14. 00
15. 00	BIOTERRORISM GRANT	192.09	1 <u>6, 4</u> 92	0	15. 00
	TOTALS		734, 201	0	
4 00	D - ADVERTISING	101.00	445 500		
1. 00	ADVERTI SI NG	1 <u>94.</u> 03	16 <u>5, 5</u> 32	4 <u>1, 1</u> 89	1.00
	TOTALS		165, 532	41, 189	
1 00	E - LEASED PROPERTY	4 00		40, 200	1.00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	40, 209 117, 207	1.00
3. 00	OPERATION OF PLANT	7. 00	o	425, 397	3.00
4. 00	HOUSEKEEPI NG	9.00	0	8, 952	4.00
5. 00	DI ETARY	10.00	0	28, 697	5. 00
6. 00	OPERATING ROOM	50.00	0	187, 213	6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	293, 297	7. 00
8. 00	CT SCAN	57. 00	0	20, 484	8. 00
9. 00	MAGNETIC RESONANCE I MAGING	58.00	0	23, 055	9. 00
7. 00	(MRI)	55. 55	Ĭ	20,000	7.00
10.00	LABORATORY	60.00	o	68, 212	10. 00
11.00	ELECTROCARDI OLOGY	69. 00	o	17, 183	11. 00
12.00	CARDI AC REHAB	69. 01	O	15, 535	12. 00
13.00	CLINIC	90.00	0	33, 910	13. 00
15.00	PARISH NURSING	192. 08	0	4, 095	15. 00
16.00	MGH PHYS PRACT MGMT	192. 14	0	46, 842	16. 00
17.00	MGH MARION SURGEONS	192. 15	0	79, 847	17. 00
18. 00	MGH FMC SOUTH	192. 17	0	335, 854	18. 00
19. 00	MGH FAIRM MED ASSOC	192. 18	0	154	19. 00
20. 00	MGH FMC MARION	192. 19	0	32, 458	20. 00
21. 00	MGH WORK SOLUTIONS	194. 04	0	9, 009	21. 00
22. 00	MGH FMC NORTHWOOD	193. 01	0	1, 239	22. 00
23. 00	MGH FMC GAS CITY	193. 02	0	2, 385	23. 00
24. 00	MGH FMC SWAYZEE	193. 05	0	24, 768	24. 00
25. 00	MGH PEDIATRIC CTR	193.06	O O	65, 961	25. 00
26. 00	MGH SPECIALTY PHYS	193. 07	O O	40, 896	26. 00
27. 00 28. 00	MGH FMC CONVERSE	193. 08 193. 09	0	154	27. 00 28. 00
	MGH UPLAND HEALTH		0	6, 345	29. 00
29. 00 30. 00	MGH MGH PSYCHIATRY	193. 11	0	14, 132 6, 392	30.00
30.00	OB/GYN	193.12		<u>6, 392</u> 1, 949, 882	30.00
	F - PHARMACY RECLASS		<u> </u>	1, 747, 002	
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	6, 002, 249	1. 00
1.00	TOTALS	70.00	— — ŏ	6, 002, 249	1.00
	G - CT/MRI RECLASS			-,,,	
1.00	CT SCAN	57.00	448, 053	404, 752	1. 00
2.00	MAGNETIC RESONANCE I MAGING	58. 00	258, 425	233, 460	2. 00
	(MRI)				
	TOTALS		706, 478	638, 212	
	H - SHORT TERM DISABILITY REC				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11, 311	 1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	55, 974	2. 00
4.00	PHARMACY	15. 00	0	4, 622	4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	48, 490	5. 00
6. 00	INTENSIVE CARE UNIT	31.00	0	13, 414	 6. 00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 150011

Peri od: From 07/01/2014 To 06/30/2015

Date/Time Prepared: 11/23/2015 7:14 am

Cost Center Line 2			Increases			1172372013 7	14 4111
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10.00 CARGINAC CATHELRIA AT 100 59.00 0 1.724 110.00	8.00	OPERATING ROOM	50.00	0	6, 541		8. 00
11.00	9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	11, 275		9. 00
12.00	10.00	CARDIAC CATHETERIZATION	59.00	0	1, 724		10.00
13.00 Control Contro	11. 00	LABORATORY	60.00	0	6, 453		11. 00
14.00 PAYSICAL THERRY	12.00	ONCOLOGY	60. 01	0	2, 413		12. 00
15.00 ELECTROCABIOLOGY	13.00	RESPIRATORY THERAPY	65.00	0	4, 218		13. 00
16.00 CLINIC 90.00 0 12 16.00 17.00 18	14.00	PHYSI CAL THERAPY		0	7, 784		14. 00
17.00	15. 00	ELECTROCARDI OLOGY		0	2, 667		15. 00
MBBULANCE SERVICES		1					
19.00 MCH PHYS PRACT MOUT 192, 14 0 1,088 19,00 20,00 MCH PKC SOUTH 192, 15 0 100 29,00 20,00 MCH PKC SOUTH 192, 17 0 3,277 21,00 MCH PKC SOUTH 192, 17 0 3,277 21,00 MCH PKC SOUTH 192, 17 0 1,180 22,10 MCH PKC SOUTH 192, 17 0 1,180 22,10 MCH PKC SOUTH 192, 17 0 1,180 22,10 MCH PKC SOUTH 193, 04 0 1,180 22,10 MCH PKC SOUTH 193, 04 0 1,180 22,20 22,00 MCH PKC PKC MARK FAM PRACT 193, 04 0 1,180 22,20 22,00 MCH PKC PKC MARK FAM PRACT 193, 04 0 2,266 22,00 MCH PKC PKC MARK FAM PRACT 193, 04 0 3,275 22,60 22,00 MCH PKC PKC MARK FAM PRACT 193, 17 0 3,275 22,00 MCH PKC PKC MARK FAM PKC PKC MARK FAM PKC			1		·		1
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24.00 MIGH MAR FAM PRACT 193.04 0 1,895 24.00 2.706 2.706 2.700 2.706 2.700 2.		1	1				1
26.00 MCH PEDIATRIC CTR		1		-			1
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K - GAINSHARE BONUS	17.00		174.04				17.00
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3. 00 OPERATION OF PLANT 7. 00 17, 742 0 3. 00 4. 00 NURSING ADMINISTRATION 13. 00 10, 067 0 5. 00 6. 00 PHARMACY 15. 00 33, 647 0 6. 00 0			1	·			1
4, 00 NURSI NG ADMINISTRATION 13, 00 10, 067 0 0 0 0 0 0 0 0 0							1
5. 00 CENTRAL SERVICES & SUPPLY 14. 00 4, 296 0 6. 00 PHARMACY 15. 00 33, 647 0 6. 00 7. 00 ADULTS & PEDIATRICS 30. 00 171, 558 0 7. 00 8. 00 INTENSIVE CARE UNIT 31. 00 41, 843 0 8. 00 9. 00 SUBPROVIDER - IRF 41. 00 19, 310 0 9. 00 10. 00 RABDI OLOGY-DIA GNOSTI C 54, 00 62, 399 0 10. 00 7. 00 11. 00 CARDI AC CATHETERI ZATI ON 59. 00 14, 162 0 11. 00 11. 00 12. 00 LABORATORY 60. 00 64, 794 0 12. 00 13. 00 14. 00 19. 00 14. 00 19. 00 14. 00 19. 00 12. 00 14. 00 19. 00 14. 00 19. 00 11. 00 12. 00 14. 00 19. 00 11. 00 12. 00 14. 00 19. 00 14. 00 19. 00 14. 00 19. 00 15. 00 15. 00 15. 00 15. 00 </td <td></td> <td></td> <td></td> <td></td> <td>ŭ</td> <td></td> <td></td>					ŭ		
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	26.00	MGH FAIRM MED ASSOC	192. 18	2, 749	0		26. 00
28.00 MGH FMC NORTHWOOD 193.01 10,893 0 28.00			1		-		1
	28. 00	MGH FMC NORTHWOOD	193. 01	10, 893	0		28.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 07/01/2014 | To 06/30/2015 | Date/Time Prepared: Provider CCN: 150011

					To 06/30/2015 Date/lime Pr 11/23/2015 7	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
29.00	MGH FMC GAS CITY	193. 02	8, 185	0		29. 00
30.00	MGH MAR FAM PRACT	193. 04	24, 448	0		30. 00
31. 00	MGH FMC SWAYZEE	193. 05	4, 092	0		31. 00
32.00	MGH PEDIATRIC CTR	193. 06	8, 578	0		32. 00
33.00	MGH SPECIALTY PHYS	193. 07	2, 759	0		33. 00
34.00	MGH FMC CONVERSE	193. 08	5, 464	0		34. 00
35. 00	MGH UPLAND HEALTH	193. 09	13, 723	0		35. 00
36.00	OB/GYN	193. 12	17, 263	0		36. 00
37. 00	MGH WORK SOLUTIONS	194. 04	10, 472	0		37. 00
38. 00	MGH TAYLOR UNIVERSITY	194.05	3, 253	0		38. 00
	TOTALS		1, 000, 000	0		_
1 00	L - COMMITMENT RECOGNITION BO		40.400			4
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	12, 193	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	161, 587	0		2.00
3.00	OPERATION OF PLANT	7.00	17, 895	0		3.00
4.00	NURSING ADMINISTRATION	13.00	10, 637	0		4.00
5. 00 6. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	4, 336	0		5. 00 6. 00
7. 00	ADULTS & PEDIATRICS	30.00	32, 822 169, 474	0		7. 00
8.00	INTENSIVE CARE UNIT	30.00	40, 895	0		8.00
9. 00	SUBPROVI DER - I RF	41.00	19, 519	0		9. 00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	63, 018	0		11. 00
12. 00	CARDI AC CATHETERI ZATI ON	59. 00	14, 303	0		12.00
13. 00	LABORATORY	60.00	64, 249	0		13. 00
14. 00	ONCOLOGY	60. 01	23, 855	Ö		14. 00
15. 00	RESPIRATORY THERAPY	65. 00	27, 120	0		15. 00
16. 00	PHYSI CAL THERAPY	66.00	26, 239	0		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	18, 257	0		17. 00
18. 00	CARDI AC REHAB	69. 01	2, 415	0		18. 00
19.00	CLINIC	90.00	1, 755	0		19. 00
20.00	EMERGENCY	91.00	79, 183	0		20. 00
21.00	AMBULANCE SERVICES	95.00	30, 613	0		21. 00
22.00	GREAT BEGINNINGS/MATERNAL	192. 03	2, 438	0		22. 00
23.00	PARISH NURSING	192. 08	1, 027	0		23. 00
24.00	MGH PHYS PRACT MGMT	192. 14	22, 390	0		24. 00
25.00	MGH MARION SURGEONS	192. 15	12, 251	0		25. 00
26. 00	MGH FMC SOUTH	192. 17	23, 705	0		26. 00
27. 00	MGH FAIRM MED ASSOC	192. 18	1, 581	0		27. 00
28. 00	MGH FMC MARION	192. 19	7, 233	0		28. 00
29. 00	MGH FMC NORTHWOOD	193. 01	10, 991	0		29. 00
30. 00	MGH FMC GAS CITY	193. 02	8, 248	0		30. 00
31. 00	MGH MAR FAM PRACT	193. 04	25, 074	0		31. 00
32. 00	MGH FMC SWAYZEE	193. 05	4, 123	0		32. 00
33.00	MGH PEDIATRIC CTR	193.06	8, 656	0		33. 00
34. 00	MGH SPECIALTY PHYS	193.07	2, 797	0		34.00
35. 00	MGH FMC CONVERSE	193.08	6, 709	0		35. 00
36. 00	MGH UPLAND HEALTH	193. 09	13, 849	0		36. 00
38. 00	OB/GYN	193. 12	17, 457	0		38. 00
39. 00	MGH WORK SOLUTIONS	194.04	10, 568	0		39.00
40. 00	MGH TAYLOR UNIVERSITY	1 <u>94.</u> 05	3, 282	0		40. 00
500 00	Grand Total: Increases		1, 002, 744 6, 023, 264	10, 485, 138		500.00
500.00	prana rotar. THCFE45E5	ı l	0, 023, 204	10, 400, 138		1 300. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2014 To 06/30/2015 Date/Ti me Prepared: 11/23/2015 7:14 am Provider CCN: 150011

						11/23/2015	7: 14 am
	0+ 0+	Decreases	C-1	0+1	WI+ A 7 D-6		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - SATELLITE OFFICE RECLASS	7.00	8.00	9.00	10.00		
1.00	LABORATORY	60.00	9, 263	4, 042	0		1.00
2.00	LABORATORY	60.00	96, 270	25, 556	0		2. 00
	TOTALS		105, 533	29, 598			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	81, 124			1.00
2. 00	TOTALS		0	<u>1, 366, 1</u> 43 1, 447, 267			2. 00
	C - ADMIN DIRECTOR RECLASS		<u> </u>	1, 447, 207			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	49, 783	0	0		1. 00
2.00	OPERATION OF PLANT	7.00	16, 492	0			2. 00
3.00	NURSING ADMINISTRATION	13. 00	575, 304	0			3. 00
4.00	INTENSIVE CARE UNIT	31.00	44, 372	0			4. 00
5. 00 6. 00	EMERGENCY	91. 00 0. 00	48, 250 0	0			5. 00 6. 00
7. 00		0.00	o	0			7. 00
8.00		0.00	Ö	0			8. 00
9.00		0.00	O	0			9. 00
11. 00		0.00	0	0			11. 00
12.00		0.00	0	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0			13. 00 14. 00
15. 00		0.00	0	0			15. 00
10.00	TOTALS — — — —		734, 201	$ \frac{9}{0}$			10.00
	D - ADVERTISING						
1.00	ADMI NI STRATI VE & GENERAL		16 <u>5, 5</u> 32	4 <u>1, 1</u> 89			1. 00
	TOTALS E - LEASED PROPERTY		165, 532	41, 189			
1. 00	NEW CAP REL COSTS-BLDG &	1.00	O	1, 211, 272	9		1.00
	FIXT			., ,			
2.00	OWNED PROPERTIES	192. 05	0	738, 610			2. 00
3. 00 4. 00		0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	0	0			5. 00
6. 00		0.00	o	0			6. 00
7.00		0.00	О	0	0		7. 00
8.00		0. 00	0	0			8. 00
9.00		0.00	0	0	-		9. 00
10. 00 11. 00		0. 00 0. 00	0	0			10. 00 11. 00
12.00		0.00	0	0			12.00
13. 00		0.00	ő	0			13. 00
15.00		0.00	O	0			15. 00
16.00		0.00	O	0			16. 00
17. 00		0.00	0	0			17. 00
18.00		0.00	0	0			18. 00
19. 00 20. 00		0. 00 0. 00	0	0			19. 00 20. 00
21. 00		0.00	o	0			21. 00
22.00		0.00	O	0	0		22. 00
23. 00		0. 00	0	0			23. 00
24. 00 25. 00		0. 00 0. 00	0	0	0		24. 00 25. 00
26. 00		0.00	0	0	0		26. 00
27. 00		0.00	ō	0	0		27. 00
28. 00		0.00	O	0	0		28. 00
29. 00		0.00	0	0	0		29. 00
30. 00	TOTALS — — — —			00 1, 949, 882	0		30. 00
	F - PHARMACY RECLASS		<u> </u>	1, 747, 002			
1.00	PHARMACY	15. 00	0	6, 002, 249			1. 00
	TOTALS G - CT/MRI RECLASS		0	6, 002, 249			_
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	706, 478	638, 212	0		1.00
2. 00	IN DE GEGGT BITTONGSTTG	0.00	0	0	0		2. 00
	TOTALS		706, 478	638, 212			
.	H - SHORT TERM DISABILITY REC						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11, 311	0			1.00
2. 00 4. 00	ADMI NI STRATI VE & GENERAL PHARMACY	5. 00 15. 00	55, 974 4, 622	0			2. 00 4. 00
4. 00 5. 00	ADULTS & PEDIATRICS	30.00	48, 490	0			5. 00
6. 00	INTENSIVE CARE UNIT	31.00	13, 414	0			6. 00
8.00	OPERATING ROOM	50.00	6, 541	0			8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	11, 275	0	0		9. 00

Peri od: From 07/01/2014 To 06/30/2015

Date/Time Prepared: 11/23/2015 7:14 am

		D				11/23/2015 /	: 14 alli
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
10. 00	CARDI AC CATHETERI ZATI ON	59.00	1, 724	7.00			10.00
	LABORATORY	60.00	6, 453	(11.00
	ONCOLOGY	60. 01	2, 413	(1		12.00
	RESPIRATORY THERAPY	65. 00	4, 218	(_		13. 00
	PHYSICAL THERAPY	66.00	7, 784	(_		14. 00
	ELECTROCARDI OLOGY	69.00	2, 667	(-		15. 00
	CLINIC	90.00	12	(1		16. 00
	EMERGENCY	91.00	8, 607	(_		17. 00
	AMBULANCE SERVICES	95. 00	1, 074	(1		18.00
	MGH PHYS PRACT MGMT	192. 14	1, 038	(_		19. 00
	MGH MARION SURGEONS	192. 14	106	(20.00
	MGH FMC SOUTH	192. 17	3, 377				21.00
	MGH FMC MARION	192. 17	1, 536	(22.00
	MGH FMC GAS CITY	193. 02	1, 901				23. 00
	MGH MAR FAM PRACT	193. 04	1, 855		_		24. 00
	MGH PEDIATRIC CTR	193.04	2, 268				26. 00
	MGH SPECIALTY PHYS	193.00	566				27. 00
	MGH UPLAND HEALTH	193.07	323	(_		28.00
	MGH MGH PSYCHIATRY	193. 09	236				29. 00
	OB/GYN	193. 11	130				30.00
30.00	TOTALS — — — —		199, 915		+		30.00
	I - NURSERY RECLASS		177, 715		/		
1.00	ADULTS & PEDIATRICS	30.00	876, 659	176, 826	0		1.00
1.00	TOTALS		876, 659	176, 826			1.00
	J - MANAGEMENT BONUS		070,037	170, 020	/		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	1, 432, 117	(0		1.00
2. 00	ADMINISTRATIVE & GENERAL	0.00	1, 432, 117	(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	(1		7. 00
8. 00		0.00	0				8.00
9. 00		0.00	0	(1		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	(ol ol		14. 00
15. 00		0.00	0	(_		15. 00
16. 00		0.00	0				16. 00
17. 00		0.00	0				17. 00
17.00	TOTALS — — — —		1, 432, 117				17.00
	K - GAINSHARE BONUS		1, 432, 117		′		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	1, 000, 000	(0		1. 00
2. 00	Control of the cont	0.00	0	(2. 00
3. 00		0.00	0	Č	o o		3. 00
4. 00		0.00	0	(1		4. 00
5. 00		0.00	0	(o o		5. 00
6. 00		0.00	Ö	C			6. 00
7. 00		0.00	0	C	1		7. 00
8. 00		0.00	Ö	Č	1		8. 00
9. 00		0.00	Ö	Č	1		9. 00
10. 00		0.00	Ö	Č	1		10.00
11. 00		0.00	Ö	(1		11. 00
12. 00		0.00	0	(12. 00
13. 00		0.00	Ö	Č	1		13. 00
14. 00		0.00	0	(14. 00
15. 00		0.00	0	(1		15. 00
16. 00		0.00	Ö	Č	1		16. 00
17. 00		0.00	Ö	(17. 00
18. 00		0.00	Ö	Č	-		18. 00
19. 00		0.00	Ö	(1		19. 00
20. 00		0.00	Ö	(1		20. 00
21. 00		0.00	Ö	C	1		21. 00
22. 00		0.00	0	(1		22. 00
23. 00		0.00	0	(1		23. 00
24. 00		0.00	0	(24. 00
25. 00		0.00	0	(1		25. 00
26. 00		0.00	0	(26. 00
27. 00		0.00	0	(27. 00
28. 00		0.00	0	(28. 00
29. 00		0.00	0	(29. 00
30. 00		0.00	Ö	C			30.00
	1	2.00	9		,		

Period: From 07/01/2014 To 06/30/2015 Worksheet A-6 Bate/Time Prepared: 11/23/2015 7: 14 am

						11/23/2015 7	:14 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
31. 00		0.00	0		0		31. 00
32.00		0.00	O		0 0		32. 00
33.00		0.00	o		0 0		33. 00
34. 00		0.00	o		o o		34. 00
35. 00		0.00	Ö		0 0	l .	35. 00
36. 00		0.00	Ö		o o	l .	36. 00
37. 00		0.00	Ö		0 0		37. 00
38. 00		0.00	o		0 0		38. 00
36.00	TOTALS — — — —	0.00	1, 000, 000		<u> </u>		36.00
	L - COMMITMENT RECOGNITION BO	JMITE	1,000,000		U		-
1 00	ADMINISTRATIVE & GENERAL	5. 00	1, 001, 220		0 0		1 00
1.00	OPERATING ROOM				0 0		1.00
2.00		50.00	345				2.00
3.00	MGH MGH PSYCHLATRY	193. 11	1, 179		0	l .	3. 00
4.00		0.00	0		0		4. 00
5.00		0.00	0		0		5. 00
6.00		0.00	0		0	l .	6. 00
7.00		0.00	0		0		7. 00
8.00		0.00	0		0	l .	8. 00
9.00		0.00	0		0		9. 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	O		0 0		14. 00
15.00		0.00	O		0 0		15. 00
16.00		0.00	0		0 0		16. 00
17.00		0.00	o		0 0		17. 00
18. 00		0.00	0		0 0		18. 00
19. 00		0.00	Ö		o o		19. 00
20. 00		0.00	Ö		o o		20.00
21. 00		0.00	o		0 0		21. 00
22. 00		0.00	o		0 0		22. 00
23. 00		0.00	o		0 0		23. 00
24. 00		0.00	0		0 0		24. 00
		0.00	0		0 0		
25. 00							25. 00
26.00		0.00	0				26. 00
27. 00		0.00	0		0		27. 00
28. 00		0.00	0		0		28. 00
29. 00		0.00	0		0		29. 00
30.00		0.00	0		0		30. 00
31. 00		0.00	0		0		31. 00
32. 00		0.00	0		0		32. 00
33.00		0.00	0		0		33. 00
34.00		0.00	0		0		34. 00
35.00		0.00	0		0		35. 00
36.00		0.00	0		0		36. 00
38.00		0.00	0		0 0		38. 00
39.00		0.00	0		0 0		39. 00
40.00		0.00	o		0 0		40.00
	TOTALS		1, 002, 744		<u> </u>		
500.00	Grand Total: Decreases		6, 223, 179	10, 285, 22	3		500.00
	•			· · · · · · · · · · · · · · · · · · ·	•	•	

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 07/01/2014 Part I

				T	o 06/30/2015	Date/Time Pre 11/23/2015 7:	pared: 14 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s 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	4, 422, 248	0	C	0	0	1. 00
2.00	Land Improvements	3, 262, 659	79, 097	C	79, 097	0	2. 00
3.00	Buildings and Fixtures	108, 317, 369	8, 428, 916	C	8, 428, 916	8, 536, 406	3. 00
4.00	Building Improvements	859, 249	12, 077	C	12, 077	0	4. 00
5.00	Fixed Equipment	1, 098, 638	100, 320	C	100, 320	193, 350	5. 00
6.00	Movable Equipment	74, 920, 817	4, 551, 767	C	4, 551, 767	1, 614, 304	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	192, 880, 980	13, 172, 177	C	13, 172, 177	10, 344, 060	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	192, 880, 980	13, 172, 177	C	13, 172, 177	10, 344, 060	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	4, 422, 248	0				1. 00
2.00	Land Improvements	3, 341, 756	0				2. 00
3.00	Buildings and Fixtures	108, 209, 879	0				3. 00
4.00	Building Improvements	871, 326	0				4. 00
5.00	Fixed Equipment	1, 005, 608	0				5. 00
6.00	Movable Equipment	77, 858, 280	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	195, 709, 097	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	195, 709, 097	0				10. 00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150011	Peri od:	Worksheet A-7	
					From 07/01/2014 To 06/30/2015		nared:
					10 00/30/2013	11/23/2015 7:	
			SU	JMMARY OF CAP	I TAL		
		D				T /	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11. 00	12. 00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00	
1.00	NEW CAP REL COSTS-BLDG & FLXT	12, 658, 568			0 0	0	1.00
3.00	Total (sum of lines 1-2)	12, 658, 568	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Relate					
		d Costs (see instructions)	through 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	12, 658, 568				1.00
3.00	Total (sum of lines 1-2)	0	12, 658, 568				3. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 07/01/2014 Fo 06/30/2015		
					11/23/2015 7: 1	14 am_
	COM	PUTATION OF RAT	108	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col.			
			2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	192, 902, 639	0	192, 902, 639	1.000000	0	1.00
3.00 Total (sum of lines 1-2)	192, 902, 639	0	192, 902, 639	1.000000	0	3.00
	ALLOCA	TION OF OTHER C	API TAL	SUMMARY O	F CAPITAL	
0 1 0 1 0 1 1		0.11	T			
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	4 00	d Costs	through 7)	0.00	10.00	
DADT III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS			44 440 005		
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(1.1, 1.10, 000		1. 00
3.00 Total (sum of lines 1-2)	0	0	(11, 448, 085	0	3. 00
		SL	IMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
· ·				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 & FLXT	-208, 305	0	(0	11, 239, 780	1. 00
3.00 Total (sum of lines 1-2)	-208, 305	l .			11, 239, 780	3. 00
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Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provi der CCN: 150011 Peri od: Worksheet A-8 From 07/01/2014 To 06/30/2015 Date/Time Prepared:

Pagement Circum In North-Steel A Pagement Circum Structure Pagement Circum Struc					To	06/30/2015	Date/Time Prep 11/23/2015 7:	
Cost Center Description Sasis/Code (2) Anount Cost Center Line					Expense Classification on	Worksheet A	11/23/2013 7.	14 alli
1.00 Investment I mome - NEK CAP NEW CAP					To/From Which the Amount is	to be Adjusted		
1.00 Investment I mome - NEK CAP NEW CAP								
1.00 Investment I mome - NEK CAP NEW CAP								
1.00 Investment I mome - NEK CAP NEW CAP								
		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
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Chepter 2) Chapter 2) Chapter 3) Chapter 4) Chapter 5) Chapter 5) Chapter 5) Chapter 5) Chapter 6) Chapter 6) Chapter 6) Chapter 6) Chapter 7) Chapter 6) Chapter 7) Chapte		II.						
1.00 Content	3.00	II.		0		0. 00	0	3.00
discounts (chipter 8)								
Section Sect	4.00			0		0.00	0	4. 00
Exemples (Chapter 8)	5 00			0		0.00	0	5 00
Suppliers (chapter 8)	0.00	II.		· ·		0.00		0.00
Telephone services (pay stations excluded) (chapter 21)	6.00			0		0. 00	0	6. 00
Stations excluded) (chapter 20				_			_	
21	7.00			0		0.00	0	7.00
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10.00 Provider-based physician A-8-2 -401, 661 adjustment 11.00 Sale of scrap, waste, etc. (Chapter 23) 0 0 0 0 0 0 0 11.00 0 0 12.00 0 13.00 0								
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Chapter 23)	11 00			0		0.00	0	11 00
12.00 Related organization Canada	11.00			0		0.00	Ĭ	11.00
13.00 Laundry and I inen service 0 0.00 0 13.00	12.00	Related organization	A-8-1	0			O	12.00
14.00 Carfeteria - employees and guests B -21,137/CAFETERIA 6.01 0,14.00 15.00 15.00 16.00		1 ' '						
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 15.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 17.00 18.00				0	OA SETERIA			
and others				-21, 137	CAFETERIA		-	
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patients	16. 00			0		0.00	О	16.00
17. 00 Sale of drugs to other than patients 0 0.00								
patients	47.00					0.00		47.00
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abstracts	18 00			0		0.00	0	18 00
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20. 00 Vending machines 0 0.0	19. 00			0		0. 00	0	19. 00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings therapy costs in excess of limitation (chapter 14)	00.00					0.00		00.00
Interest, finance or penal ty charges (chapter 21)				0			-	
Charges (chapter 21)	21.00			0		0.00	Ĭ	21.00
overpayment's and borrowings to repay Medicare overpayments 23. 00 Adjustment for respiratory therapy costs in excess of limit ation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limit ation (chapter 14) 25. 00 Utilization review - physical chapter 21) 26. 00 Depreciation - NEW CAP REL COSTS-BLDG & 1. 00 CostSS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & 1. 00 CostSS-BLDG & FIXT 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 20. 00 O Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Physicians' assistant 30. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 30. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 30. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 30. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 30. 00 CAH HIT Adjustment for Depreciation and Interest								
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therapy costs in excess of		1 1 3						
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25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & 1.00 0 27.00 COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
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32.00 CAH HIT Adjustment for 0 Depreciation and Interest 0 0.00 0 32.00								
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	33. 00	Soprooration and interest		0		0. 00	ol	33. 00
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Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 150011

Expense Classification on Anothsheet A ToPriron Which the Anount is to be all justed					T	06/30/2015	Date/Time Prep 11/23/2015 7:	
Const. Centur Description								
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1.00 2.00 3.00 4.00 5.00 3.0 3.00 3								
1.00 2.00 3.00 4.00 5.00 3.0 3.00 3								
33.01 PRILIMED CHECK FEE 8		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
33.02 FINESCLAIN PRILY APPLIC 8	22.01	DETUDNED CHECK FEE						22 01
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OHILD SEAT SAETY INSPECTION B		SALE OF MEDICAL RECORDS &			1		0	
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33. 20 AMBULANCE SUC - ASSISTS B -72, 125 AMBULANCE SERVICES 95, 00 0 33, 20		d control of the cont			1			
33. 21 AMBULANCE SVC - CORONER SVC B B -744 AMBULANCE SERVICES 95.00 0 33. 21 33. 22 AMBULANCE SVC - COMMUNITY B B -1.000 AUDITORY & B 0.00 AUDITORY & B 0.0					1			
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33. 22 PHLEBOTOMY	33. 26	4	В	-6, 000	 ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
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33 30 SICK CHILD CARE PROGRAM B -587/ADULTS & PEDIATRICS 30.00 0 33.30 33.31		1			li de la companya de			
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33. 32 VENDING MACHINES B -2,759 CAPTERIA 6,01 0 33. 32 33. 33 CPR TRAIN OTH AHA COMMUNITY B -5,149 ADMINISTRATIVE & GENERAL 5.00 0 33. 33 33. 34 PHYSI CIAN RECRUITMENT A -964,093 ADMINISTRATIVE & GENERAL 5.00 0 33. 35 33. 35 ED ANESTHESI OLOGIST A -1,300,079 ADMINISTRATIVE & GENERAL 5.00 0 33. 36 33. 36 GAI NO NO ISPOSOAL A -14,205 ADMINISTRATIVE & GENERAL 5.00 0 33. 37 33. 37 TELEPHONE SERVICE A -16,872 OPERATION OF PLANT 7.00 0 33. 38 33. 49 TELEPHONE SERVICE A -16,872 OPERATION OF PLANT 7.00 0 33. 40 33. 40 MISC REV B -2,630 ADMINISTRATIVE & GENERAL 5.00 0 33. 40 34. 41 MISC REV B -2,630 ADMINISTRATIVE & GENERAL 5.00 0 33. 42 35. 42 ENFERTAL MINENT EXP A -562 ADMINISTRATIVE & GENERAL 5.00		UNCLAIMED OTHER 125 MED/CHILD	•		ł .			
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33. 36 GAIN ON DISPOSAL A -14, 205 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 36 33. 37 TELEPHONE SERVI CE A -9, 792 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 39 33. 39 TELEPHONE SERVI CE A -9, 792 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 39 33. 40 MISC REV B -2, 630 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 39 33. 41 MISC REV B -2, 630 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 41 33. 42 ENTERTIAI NMENT EXP A -562 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 42 33. 43 EMPLOYEE USE OF AUTO A -4, 724 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 42 33. 45 VHA OPPORTUNI TY A -266, 534 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 45 34. 40 DONATI ONS A -4, 244 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 45 35. 40 VHA OPPORTUNI TY A -22, 282 ADMI NI STRAT		1					0	
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Provi der CCN: 150011 Peri od: Worksheet A-8 Peri od: From 07/01/2014 To 06/30/2015 Date/Ti me Prepared: 11/23/2015 7: 14 am

						11/23/2015 7:	14 am
				Expense Classification on	Worksheet A		
				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. 64	VHA OPPORTUNI TY	А	-237	CLINIC	90.00	0	33. 64
33. 65	VHA OPPORTUNI TY	A	-1, 584	EMERGENCY	91.00	0	33. 65
33. 66	VHA OPPORTUNI TY	A	-220	AMBULANCE SERVICES	95. 00	0	33. 66
33. 67	FINANCE BANK SERVICE CHARGES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 67
33. 68	FINANCE DISCOUNT PAYMENTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 68
33. 69	NONALLOWABLE 2008 BONDS	A	•	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 69
			,	FIXT		• • •	
33. 70	BLDG COSTS	A	789	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 70
				FIXT		•	
33. 71	ELIMINATING ENTRIES	A	-63, 467	MGH PHYS PRACT MGMT	192. 14	0	33. 71
33. 72	ELIMINATING ENTRIES	A		MGH WORK SOLUTIONS	194. 04	0	33. 72
33. 73	ELIMINATING ENTRIES	A		MGH MARION SURGEONS	192. 15	0	33. 73
33. 74	ELIMINATING ENTRIES	A		MGH FMC MARION	192. 19	0	33. 74
33. 75	ELIMINATING ENTRIES	A	•	MGH FMC SWAYZEE	193. 05	0	33. 75
33. 76	ELIMINATING ENTRIES	A	•	MGH PEDIATRIC CTR	193. 06	0	33. 76
33. 77	ELIMINATING ENTRIES	A	•	MGH MGH PSYCHIATRY	193. 11	0	33. 77
33. 78	ELIMINATING ENTRIES	A	•	MGH SPECIALTY PHYS	193. 07	0	33. 78
33. 79	ELIMINATING ENTRIES	A		MGH FMC SOUTH	192. 17	0	33. 79
33. 80			020,277		0.00	0	33. 80
33. 81	LOBBYING COSTS	A	-17 268	ADMINISTRATIVE & GENERAL	5. 00	0	33. 81
33. 82	LOBBYING COSTS	A	•	NURSING ADMINISTRATION	13. 00	0	33. 82
33. 83	LOBBYING COSTS	A		PHARMACY	15. 00	Ö	33. 83
33. 84	LOBBYING COSTS	A		ONCOLOGY	60. 01	0	33. 84
33. 85	OPERATING INTEREST INCOME	B		NEW CAP REL COSTS-BLDG &	1. 00	11	33. 85
33. 03	OF ERATTING TINTEREST TINCOME		-40, 307	FIXT	1.00	''	33.03
33. 86	ED ON CALL SVC A/C 7000.2512	A	_2 147 784	ADMINISTRATIVE & GENERAL	5. 00	0	33. 86
33. 87	XIX ASSESSMENT FEE A/C	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	33. 87
55.07	7200. 7892	^	1, 347, 234	ADMINISTRATIVE & GENERAL	5.00		55.07
33. 88	SELF INSURANCE EXPENSE	A	-1 316 494	EMPLOYEE BENEFITS DEPARTMENT	4. 00	n	33. 88
33. 89	PENSION ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	n	33. 89
50. 00	TOTAL (sum of lines 1 thru 49)		-638, 580		7. 00	Ĭ	50. 00
30. 00	(Transfer to Worksheet A,		030, 300				30.00
	column 6, line 200.)						
	COT GIIIIT O, 11110 200.)			1			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

							To 06/30/2015	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi on	al	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component		Component		ider Component	
						•		Hours	
	1. 00	2. 00	3. 00	4. 00		5. 00	6. 00	7. 00	
1.00	41. 00	SUBPROVIDER - IRF	13, 400	13,	400	(0	0	1. 00
2.00		ELECTROCARDI OLOGY	53, 655	53,	655	(0	0	2. 00
3.00	65.00	RESPI RATORY THERAPY	10, 606	10,	606	(0	0	3. 00
4.00	91.00	EMERGENCY	165, 000	165,	000	(0	0	4. 00
5.00	60.00	LABORATORY	9, 000	9,	000	(0	0	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	150, 000	150,	000	(0	0	6. 00
7.00	0.00		0		0	(0	0	7. 00
8.00	0.00		0		0	(0	0	8. 00
9.00	0.00		0		0	(0	0	9. 00
10.00	0.00		0		0	(0	0	10.00
200.00			401, 661	401,	661	(0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent	of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadj usted	RCE	Memberships &	Component	of Mal practice	
				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		SUBPROVIDER - IRF	0		0	(
2.00	1	ELECTROCARDI OLOGY	0		0	(-		
3.00		RESPI RATORY THERAPY	0		0	(0	0	
4.00		EMERGENCY	0		0	(0	0	
5. 00		LABORATORY	0		0	(0	0	5. 00
6.00		RADI OLOGY-DI AGNOSTI C	0		0	(0	0	6. 00
7. 00	0. 00		0		0	(0	0	7. 00
8.00	0. 00		0		0	(0	0	0.00
9.00	0. 00		0		0	(0	0	,, 00
10.00	0.00		0		0	(0	0	10. 00
200.00			0		0	(0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted R	CE	RCE	Adjustment		
		ldenti fi er	Component	Limit		Di sal I owance			
			Share of col.						
	1. 00	2.00	14 15. 00	16. 00		17. 00	18. 00		
1. 00		SUBPROVI DER - I RF	0		0	(1. 00
2. 00		ELECTROCARDI OLOGY	0		0	(•	2. 00
3.00		RESPI RATORY THERAPY	0		0	Č	1	•	3. 00
4. 00		EMERGENCY	0		0	Č		•	4. 00
5. 00		LABORATORY	0		0	(5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	0		0	Č			6. 00
7. 00	0.00				0	() 130,000	1	7. 00
8. 00	0.00		0		0	(8. 00
9. 00	0.00				0	(9. 00
10. 00	0.00		0		0	(10.00
200.00	3.00				0	(ή		200.00
200.00	1		1	l	٦	,	101,001	I	

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2014 To 06/30/2015	Part I Date/Time Pre	nared.
				10 00/ 30/ 2013	11/23/2015 7:	14 am
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	for Cost	FIXT	BENEFITS		& GENERAL	
	Allocation (from Wkst A		DEPARTMENT			
	col. 7)					
	0	1. 00	4.00	4A	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	11, 239, 780	11, 239, 780				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	25, 781, 020	424, 779	26, 205, 79	9		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	20, 284, 644	1, 855, 009	4, 570, 63	7 26, 710, 290	26, 710, 290	
6.00 00600 MAINTENANCE & REPAIRS	0	0		0	0	6. 00
6. 01 00601 CAFETERI A	1, 342, 247	147, 949		0 1, 490, 196	318, 483	
6. 02 00602 CAFETERI A	0	0 005 000	070.40	0	0	6. 02
7. 00 00700 OPERATION OF PLANT	4, 996, 817	2, 835, 283				
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	425, 552 2, 547, 539	64, 594 103, 338		0 490, 146 0 2, 650, 877		1
10. 00 01000 DI ETARY	549, 211	207, 348		0 2, 650, 877		1
13. 00 01300 NURSING ADMINISTRATION	854, 041	21, 389				
14. 00 01400 CENTRAL SERVI CES & SUPPLY	504, 729	72, 844				1
15. 00 01500 PHARMACY	2, 728, 307	93, 346				
INPATIENT ROUTINE SERVICE COST CENTERS	, , , , , , ,		, , ,	, , , , , , , , , , , , , , , , , , , ,		
30. 00 03000 ADULTS & PEDIATRICS	8, 788, 877	1, 336, 853	4, 202, 16	9 14, 327, 899	3, 062, 099	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 816, 492	305, 858	1, 350, 97	3 4, 473, 323	956, 034	31.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	1, 785, 688	289, 939	569, 95	7 2, 645, 584	565, 412	
42. 00 04200 SUBPROVI DER	0	0		0	0	1
43. 00 04300 NURSERY	1, 053, 485	0	476, 82	8 1, 530, 313	327, 057	43. 00
ANCILLARY SERVICE COST CENTERS	0.040.544	4 0/0 505	000 57	0 44 007 (44	0 440 004	F0.00
50. 00 05000 OPERATI NG ROOM	9, 319, 541	1, 069, 525	1			•
51. 00 05100 RECOVERY ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	4 750 717	422 200		0 0	1 429 102	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	4, 759, 717 873, 289	633, 288 46, 475				•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	514, 940	135, 788				•
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 385, 903	153, 760				1
60. 00 06000 LABORATORY	6, 738, 666	387, 471				•
60. 01 06001 0NCOLOGY	1, 560, 302	007, 171	554, 66			
60. 02 06002 RADIATION ONCOLOGY	0	0	33.733	0 2,, ,,	0	1
65. 00 06500 RESPIRATORY THERAPY	2, 026, 589	140, 340	735, 85	4 2, 902, 783	620, 380	1
66. 00 06600 PHYSI CAL THERAPY	1, 930, 059	26, 919	890, 26			66. 00
69. 00 06900 ELECTROCARDI OLOGY	810, 074	244, 045	401, 76	4 1, 455, 883	311, 150	69. 00
69. 01 06901 CARDI AC REHAB	143, 169	39, 630	66, 53	249, 331	53, 287	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 999, 849	0		5, 999, 849	1, 282, 282	73. 00
OUTPATIENT SERVICE COST CENTERS	205 105	0/ 522	141 47	1 /12 100	121 050	1 00 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	385, 185 4, 842, 874	86, 532 338, 736				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,042,074	330, 730	2, 100, 21	7,307,620	1, 574, 044	92.00
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	1
OTHER REIMBURSABLE COST CENTERS	<u> </u>			0 0		72.01
95. 00 09500 AMBULANCE SERVICES	1, 050, 819	126, 896	533, 20	6 1, 710, 921	365, 656	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	129, 039, 405	11, 188, 172	23, 076, 51	9 125, 858, 517	21, 189, 814	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	35, 342	41, 158	1			190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	1	0		192. 00
192. 02 19202 VISITOR MEALS	0	0		0		192. 02
192. 03 19203 GREAT BEGINNI NGS/MATERNAL	149, 812	0	80, 02			192. 03
192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES	222 210	0		0 0 332, 219		192. 04 192. 05
192. 08 19211 PARI SH NURSI NG	332, 219 65, 279	10, 450	22, 83	· ·		192. 03
192. 09 19212 BIOTERRORI SM GRANT	5, 565	10, 430	8, 97			192. 09
192. 10 19214 BREAST PUMPS	0, 303	0	1	0 14, 333		192. 10
192. 14 19210 MGH PHYS PRACT MGMT	1, 402, 567	0	543, 85	-	l	1
192. 15 19215 MGH MARION SURGEONS	2, 231, 693	0	219, 73			1
192. 16 19216 MGH MGH MED ONC	1, 015, 163	0	1	0 1, 015, 163		1
192. 17 19217 MGH FMC SOUTH	2, 441, 781	0	390, 71			1
192.18 19218 MGH FAIRM MED ASSOC	313, 838	0	34, 34			192. 18
192.19 19219 MGH FMC MARION	711, 429	0	107, 50			
193. 00 19300 NONPALD WORKERS	0	0	1	0	l .	193. 00
193. 01 19301 MGH FMC NORTHWOOD	875, 903	0	144, 76			1
193. 02 19302 MGH FMC GAS CLTY	691, 135	0	86, 83			
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT	2,742,404	0	,			
173. U4 173U4 WUT WAK FAW PKACI	2, 198, 829	0	395, 05	1 2, 593, 880	554, 361	173. U4

| Peri od: | Worksheet B | From 07/01/2014 | Part | To 06/30/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150011

				06/30/2015	Date/lime Prep 11/23/2015 7:	
		CAPI TAL			11/23/2013 /.	14 alli
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
cost center bescriptron	for Cost	FLXT	BENEFITS	Subtotal	& GENERAL	
	Allocation	IIXI	DEPARTMENT		d OLIVEIVAL	
	(from Wkst A		DELAKTIMENT			
	col . 7)					
	0	1.00	4. 00	4A	5. 00	
193. 05 19305 MGH FMC SWAYZEE	182, 839	0	38, 539	221, 378	47, 313	193. 05
193.06 19306 MGH PEDIATRIC CTR	1, 227, 299	0	133, 613	1, 360, 912	290, 853	193. 06
193. 07 19307 MGH SPECIALTY PHYS	336, 214	0	41, 745	377, 959	80, 777	193. 07
193.08 19308 MGH FMC CONVERSE	293, 580	0	62, 472	356, 052	76, 095	193. 08
193.09 19309 MGH UPLAND HEALTH	1, 327, 819	o	195, 308	1, 523, 127	325, 521	193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0	(o		193. 10
193. 11 19311 MGH MGH PSYCHIATRY	256, 896	o	25, 539	282, 435	60, 362	193. 11
193. 12 19312 OB/GYN	2, 357, 257	o	233, 367	2, 590, 624	553, 666	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	o	(0		193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	(o	o	194. 00
194. 01 07950 MOW	0	o	(0	l ol	194. 01
194.02 07951 MENTAL HEALTH	0	o	(o	0	194. 02
194. 03 07952 ADVERTI SI NG	206, 721	o	90, 035	296, 756	63, 422	194. 03
194.04 07953 MGH WORK SOLUTIONS	756, 400	o	201, 283	957, 683	204, 675	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	149, 141	o	26, 554	175, 695	37, 549	194. 05
194.08 07957 MGH SMMP BLDG	274, 017	o	(274, 017	58, 563	194. 08
194.09 07958 MGH AMBUCARE BLDG	62, 490	o	(62, 490	13, 355	194. 09
194.10 07959 MGH 106 LYONS BLDG	6, 014	o	(6, 014	1, 285	194. 10
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		o	(0	0	201. 00
202.00 TOTAL (sum lines 118-201)	151, 689, 051	11, 239, 780	26, 205, 799	151, 689, 051	26, 710, 290	202. 00

Provider CCN: 150011

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2014 | Part |
| To 06/30/2015 | Date/Time Prepared: | 11/23/2015 7:14 am

			1		11/23/2015 7:	
Cost Center Description	MAINTENANCE & REPAIRS	CAFETERI A	CAFETERI A	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	6. 00	6. 01	6. 02	7. 00	8. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	0					6.00
6. 01 00601 CAFETERI A	Ö	1, 808, 679				6. 01
6. 02 00602 CAFETERI A	0	1, 711, 907	1, 711, 907			6. 02
7. 00 00700 OPERATION OF PLANT	0	0	37, 934		704 500	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	0	Ü	106, 689 170, 682	701, 589 15, 363	8. 00 9. 00
10. 00 01000 DI ETARY		0	0	342, 474	7, 804	10.00
13. 00 01300 NURSING ADMINISTRATION	o	o	28, 055		0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	11, 890		7, 950	14. 00
15. 00 01500 PHARMACY	0	0	73, 448	154, 179	0	15. 00
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	ol	ol	387, 216	2, 208, 062	209, 069	30.00
31. 00 03100 NTENSI VE CARE UNI T		0	108, 361		43, 854	31.00
40. 00 04000 SUBPROVI DER - PF	o	o	. 00, 00 i	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	o	53, 721	478, 888	23, 297	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	43, 575	0	0	43. 00
50. 00 05000 OPERATING ROOM	0	ol	84, 984	1, 766, 521	123, 248	50.00
51.00 05100 RECOVERY ROOM	o	0	·		0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	121, 096		57, 475	54. 00
57. 00 05700 CT SCAN	0	0	22, 889		14, 539	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION		0	13, 201 30, 093		62 9, 345	58. 00 59. 00
60. 00 06000 LABORATORY		ő	136, 072		553	60.00
60. 01 06001 0NCOLOGY	0	0	· C	l	6, 759	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0	0	0	0	60. 02
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0	56, 086		7, 711	65. 00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY		0	32, 876 39, 071		18, 387 5, 508	66. 00 69. 00
69. 01 06901 CARDI AC REHAB	o	Ö	6, 211		66	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	· C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
90. 00 09000 CLI NI C	O	ol	10, 537	142, 925	5, 018	90.00
91. 00 09100 EMERGENCY	o	Ö	200, 193		117, 127	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART)	0	0	C	0	0	92. 01
95. 00 OP500 AMBULANCE SERVICES	O	o	66, 003	209, 592	24, 827	95. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u></u>	00,000	207, 072	21,027	70.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 711, 907	1, 563, 512	9, 786, 493	697, 962	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol	947	67, 980	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		o	0	07, 780		192. 00
192.02 19202 VISITOR MEALS	O	96, 772	C	0		192. 02
192. 03 19203 GREAT BEGINNINGS/MATERNAL	0	0	C	0		192. 03
192. 04 19204 LI FELI NE	0	0	0	0		192. 04 192. 05
192. 05 19205 0WNED PROPERTIES 192. 08 19211 PARISH NURSING		O O	2, 317	17, 260		192. 05 192. 08
192. 09 19212 BI OTERRORI SM GRANT	o	Ö	2, 31,	0		192. 09
192.10 19214 BREAST PUMPS	0	0	C	0		192. 10
192.14 19210 MGH PHYS PRACT MGMT	0	0	62, 340			192. 14
192. 15 19215 MGH MARION SURGEONS 192. 16 19216 MGH MGH MED ONC	0	0	28, 458	0		192. 15 192. 16
192. 17 19217 MGH FMC SOUTH		0	0	0		192. 16
192. 18 19218 MGH FAIRM MED ASSOC		ol	C	ol ol		192. 17
192.19 19219 MGH FMC MARION	o	o	17, 416	o	216	192. 19
193. 00 19300 NONPALD WORKERS	0	0	C	O		193. 00
193. 01 19301 MGH FMC NORTHWOOD	0	0	0			193. 01
193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH HOSPITALISTS		O O	0			193. 02 193. 03
193. 04 19304 MGH MAR FAM PRACT		ol	C	ol ol		193. 03
193.05 19305 MGH FMC SWAYZEE	0	o	C	o	0	193. 05
193. 06 19306 MGH PEDIATRIC CTR	0	0	21, 433			193. 06
193. 07 19307 MGH SPECIALTY PHYS 193. 08 19308 MGH FMC CONVERSE	0	0	5, 744			193. 07 193. 08
193. 09 19309 MGH UPLAND HEALTH		ol	C	ol		193. 09
	1	-1				

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

| Peri od: | Worksheet B | From 07/01/2014 | Part | To 06/30/2015 | Date/Time Prepared: Provider CCN: 150011

				00/30/2013	11/23/2015 7:	
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6. 01	6. 02	7. 00	8. 00	
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHLATRY	0	0	2, 775	0	0	193. 11
193. 12 19312 OB/GYN	0	0	0	0	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
194.00 07963 OTHER NONREI MBURSABLE	0	0	0	0	0	194. 00
194. 01 07950 MOW	0	0	0	0	0	194. 01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	6, 965	0	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	310	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	1, 808, 679	1, 711, 907	9, 871, 733	701, 589	202. 00

Provider CCN: 150011

			To	06/30/2015	Date/Time Pre 11/23/2015 7:	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	14 diii
	9. 00	10.00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS 1. 00	3, 403, 465 48, 927 15, 290	1, 317, 455 0	1, 676, 374			1. 00 4. 00 5. 00 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY I NPATIENT ROUTINE SERVICE COST CENTERS	76, 448 48, 927	0	76, 777	1, 026, 016 0	5, 330, 659	14. 00 15. 00
30. 00 03000 ADULTS & PEDIATRICS	709, 435	784, 502	404, 768	297, 547	0	30.00
31.00 03100 INTENSIVE CARE UNIT	195, 707	136, 706	113, 273	102, 602	0	31. 00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0 171, 244	0 131, 808	0 56, 156	0 20, 520	0	40. 00 41. 00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY		0	45, 551	0	0	42. 00 43. 00
ANCILLARY SERVICE COST CENTERS	<u> </u>		10, 001	<u> </u>		10.00
50. 00 05000 OPERATING ROOM	501, 499	0	88, 837	174, 423	0	50. 00
51. 00 05100 RECOVERY ROOM	152.004	0	124 100	0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	152, 896 9, 174	0	134, 100 23, 927	20, 520	0	54. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	7, 174	0	13, 799	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	61, 158	0	31, 458	20, 520	0	59. 00
60. 00 06000 LABORATORY	171, 244	0	157, 991	51, 301	0	60. 00
60. 01 06001 0NCOLOGY	0	0	53, 642	2, 565	0	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY 65. 00 06500 RESPI RATORY THERAPY	128, 433	0	0 64, 648	56, 431	0	60. 02 65. 00
66. 00 06600 PHYSI CAL THERAPY	120, 433	0	66, 498	30, 431	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	82, 564	Ö	41, 583	4, 104	0	69. 00
69. 01 06901 CARDI AC REHAB	91, 738	0	6, 493	0	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 5, 330, 659	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>	3, 330, 037	73.00
90. 00 09000 CLI NI C	61, 158	0	11, 015	0	0	90. 00
91. 00 09100 EMERGENCY	684, 974	14, 552	209, 269	112, 862	0	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	O	0	92. 01
95. 00 09500 AMBULANCE SERVI CES	21, 405	0	68, 995	10, 260	0	95. 00
SPECIAL PURPOSE COST CENTERS	,					
113.00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	3, 232, 221	1, 067, 568	1, 668, 780	873, 655	5, 330, 659	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 116	0	0	O	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0,110	Ö	Ö	o		192. 00
192.02 19202 VISITOR MEALS	0	0	0	O		192. 02
192. 03 19203 GREAT BEGINNI NGS/MATERNAL	0	0	0	0		192. 03
192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES	12, 232	0	0	0		192. 04 192. 05
192. 08 19211 PARI SH NURSI NG	6, 116	0	7, 594	0		192. 03
192. 09 19212 BI OTERRORI SM GRANT	0	0	0	ō		192. 09
192.10 19214 BREAST PUMPS	0	0	0	0		192. 10
192. 14 19210 MGH PHYS PRACT MGMT	24, 463	0	0	0		192. 14
192.15 19215 MGH MARION SURGEONS 192.16 19216 MGH MGH MED ONC	0	0	0	29, 241		192. 15 192. 16
192. 17 19217 MGH FMC SOUTH	122, 317	0	Ö	20, 520		192. 17
192.18 19218 MGH FAIRM MED ASSOC	0	0	o	О	0	192. 18
192. 19 19219 MGH FMC MARION	0	0	0	20, 520		192. 19
193. 00 19300 NONPALD WORKERS	0	0	0	0 545		193.00
193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY		0	0	2, 565 10, 260		193. 01 193. 02
193. 03 19303 MGH HOSPI TALI STS		Ö	Ö	0		193. 03
193.04 19304 MGH MAR FAM PRACT	0	0	0	30, 780	0	193. 04
193. 05 19305 MGH FMC SWAYZEE	0	0	0	2, 565		193. 05
193. 06 19306 MGH PEDIATRIC CTR 193. 07 19307 MGH SPECIALTY PHYS	0	0	0	2, 565 0		193. 06 193. 07
193. 08 19308 MGH FMC CONVERSE		0	0	2, 565		193. 07
	-1	-	-1	,		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 MARION GENERAL HOSPITAL Provider CCN: 150011

					11/23/2015 7:	14 am_
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	9.00	10.00	13. 00	14. 00	15. 00	
193. 09 19309 MGH UPLAND HEALTH	0	0	0	20, 520	0	193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHLATRY	0	0	0	o	0	193. 11
193. 12 19312 OB/GYN	0	0	0	o	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	o	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	o	0	0	o	0	194. 00
194. 01 07950 MOW	o	150, 719	0	o	0	194. 01
194.02 07951 MENTAL HEALTH	O	99, 168	0	o	0	194. 02
194. 03 07952 ADVERTI SI NG	O	0	0	o	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	o	0	0	10, 260	0	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	o	0	0	o	0	194. 05
194.08 07957 MGH SMMP BLDG	o	0	0	o	0	194. 08
194.09 07958 MGH AMBUCARE BLDG	o	0	0	o	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	o	0	0	o	0	194. 10
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	l o	0	l 0	o	0	201.00
202.00 TOTAL (sum lines 118-201)	3, 403, 465	1, 317, 455	1, 676, 374	1, 026, 016	5, 330, 659	202. 00

| Peri od: | Worksheet B | From 07/01/2014 | Part I | To 06/30/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150011

					To 06/30/2015 Date/Time Pr	
	Cost Center Description	Subtotal	Intern &	Total	11/23/2015 7	7: 14 am
			Residents Cost			
			& Post Stepdown			
			Adjustments			
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS					5. 00
6. 01	00601 CAFETERI A					6. 00 6. 01
6. 02	00602 CAFETERI A					6. 02
7.00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING					8. 00 9. 00
10.00	01000 DI ETARY					10.00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY					14. 00 15. 00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					15.00
30.00	03000 ADULTS & PEDIATRICS	22, 390, 597	0	22, 390, 597	7	30.00
	03100 NTENSI VE CARE UNI T	6, 635, 042	1 1	6, 635, 042	2	31.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	4, 146, 630		4, 146, 630		40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	O	.,		42. 00
43.00	04300 NURSERY	1, 946, 496	0	1, 946, 496	5	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	16, 439, 540	O	16, 439, 540		50.00
51. 00	05100 RECOVERY ROOM	0	1	10, 437, 340		51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 699, 122	l l	9, 699, 122		54. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 559, 412 1, 211, 742	1 1	1, 559, 412 1, 211, 742		57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION	3, 900, 834	l l	3, 900, 834		59.00
60.00	06000 LABORATORY	11, 455, 510	O	11, 455, 510	D	60.00
60. 01	06001 ONCOLOGY	2, 629, 946	1 1	2, 629, 946		60. 01
60. 02 65. 00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	4, 068, 270	0	4, 068, 270))	60. 02 65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 617, 977	0	3, 617, 977		66. 00
69.00	06900 ELECTROCARDI OLOGY	2, 342, 948	1 1	2, 342, 948		69. 00
69. 01 71. 00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	472, 583	0	472, 583	3	69. 01 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		Ö	C		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 612, 790	0	12, 612, 790	D	73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	974, 891	O	974, 891	1	90.00
91. 00	09100 EMERGENCY	10, 840, 932		10, 840, 932		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	_		92.00
92. 01	O9201 OBSERVATION BEDS (DISTINCT PART)	0	0	C)	92. 01
95. 00	09500 AMBULANCE SERVICES	2, 477, 659	0	2, 477, 659		95. 00
440.00	SPECIAL PURPOSE COST CENTERS	ı	1			
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	119, 422, 921	0	119, 422, 921		113. 00 118. 00
	NONREI MBURSABLE COST CENTERS	1177 122772	9	,,	1	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	181, 680	l l	181, 680		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS	96, 772	1 -1	96, 772		192. 00 192. 02
	19203 GREAT BEGINNINGS/MATERNAL	278, 951		278, 951		192. 03
	19204 LI FELI NE	0	0	0		192. 04
	19205 OWNED PROPERTIES 19211 PARISH NURSING	415, 453 152, 921	1	415, 453 152, 921		192. 05 192. 08
	19212 BI OTERRORI SM GRANT	17, 641	0	17, 641		192. 09
	19214 BREAST PUMPS	0		C		192. 10
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	2, 449, 217 3, 033, 044	0	2, 449, 217 3, 033, 044		192. 14 192. 15
	19216 MGH MGH MED ONC	1, 232, 123		1, 232, 123		192. 15
192. 17	19217 MGH FMC SOUTH	3, 581, 308	0	3, 581, 308	3	192. 17
	19218 MGH FALRM MED ASSOC 19219 MGH FMC MARION	422, 602	1	422, 602 1 032 107		192. 18 192. 19
	19219 MGH FMC MARION 19300 NONPALD WORKERS	1, 032, 107		1, 032, 107 0		192. 19
193. 01	19301 MGH FMC NORTHWOOD	1, 241, 364	0	1, 241, 364		193. 01
	19302 MGH FMC GAS CITY	954, 759	1	954, 759		193. 02
	19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	3, 370, 789 3, 179, 550	1	3, 370, 789 3, 179, 550		193. 03 193. 04
193. 05	19305 MGH FMC SWAYZEE	271, 256	1	271, 256		193. 05
193.06	19306 MGH PEDIATRIC CTR	1, 676, 203	0	1, 676, 203	3	193. 06

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MARION GENERAL HOSPITAL

Provider CCN: 150011

			10	11/23/2015 7:	
Cost Center Description	Subtotal	Intern &	Total	, = =	
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25. 00	26. 00		
193. 07 19307 MGH SPECIALTY PHYS	464, 570	0	464, 570		193. 07
193.08 19308 MGH FMC CONVERSE	434, 768	0	434, 768		193. 08
193.09 19309 MGH UPLAND HEALTH	1, 870, 264	0	1, 870, 264		193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0	0		193. 10
193. 11 19311 MGH MGH PSYCHLATRY	345, 572	0	345, 572		193. 11
193. 12 19312 OB/GYN	3, 144, 290	0	3, 144, 290		193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0		193. 15
194.00 07963 OTHER NONREI MBURSABLE	0	0	0		194. 00
194. 01 07950 MOW	150, 719	0	150, 719		194. 01
194.02 07951 MENTAL HEALTH	99, 168	0	99, 168		194. 02
194. 03 07952 ADVERTI SI NG	367, 143	0	367, 143		194. 03
194.04 07953 MGH WORK SOLUTIONS	1, 172, 928	0	1, 172, 928		194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	213, 244	0	213, 244		194. 05
194.08 07957 MGH SMMP BLDG	332, 580	0	332, 580		194. 08
194.09 07958 MGH AMBUCARE BLDG	75, 845	0	75, 845		194. 09
194.10 07959 MGH 106 LYONS BLDG	7, 299	0	7, 299		194. 10
200.00 Cross Foot Adjustments	0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	151, 689, 051	0	151, 689, 051		202. 00

Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011 Peri od: Worksheet B From 07/01/2014 Part II 06/30/2015 Date/Time Prepared: 11/23/2015 7:14 am CAPI TAL RELATED COSTS Di rectly NEW BLDG & ADMI NI STRATI VE Cost Center Description Subtotal **EMPLOYEE** Assigned New FLXT **BENEFITS** & GENERAL DEPARTMENT Capi tal Related Costs 1.00 2A 4.00 5.00 0 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 424, 779 424, 779 424, 779 5.00 00500 ADMINISTRATIVE & GENERAL 0 1, 855, 009 1, 855, 009 74, 067 1, 929, 076 6.00 00600 MAINTENANCE & REPAIRS 0 0 0 00601 CAFETERI A 147, 949 6 01 147, 949 23, 001 0 6.02 00602 CAFETERI A \cap 7.00 00700 OPERATION OF PLANT 2, 835, 283 2, 835, 283 4, 378 125, 058 00800 LAUNDRY & LINEN SERVICE 0 0 8 00 64 594 64 594 0 7, 565 9.00 00900 HOUSEKEEPI NG 103, 338 103, 338 0 40, 916 10.00 01000 DI ETARY 207, 348 207, 348 11, 677 13.00 01300 NURSING ADMINISTRATION 21, 389 21, 389 7, 148 20, 318

MCRI F32 - 8. 1. 158. 3

| Peri od: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared: | Provider CCN: 150011

				10 00/30/2013	11/23/2015 7:	
Cost Center Description	Directly Assigned New	CAPITAL RELATED COSTS NEW BLDG & FLXT	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 00	
193.06 19306 MGH PEDIATRIC CTR	0	0		0 2, 166		
193. 07 19307 MGH SPECIALTY PHYS	0	0		0 677		193. 07
193. 08 19308 MGH FMC CONVERSE	0	0		0 1, 013		193. 08
193.09 19309 MGH UPLAND HEALTH	0	0		0 3, 166		
193. 10 19310 MGH MGH WOMENS CTR	0	0		0		193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0 414		193. 11
193. 12 19312 OB/GYN	0	0		0 3, 783		1
193.15 19315 MGH RIVER VIEW BLDG	0	0		0		193. 15
194. 00 07963 OTHER NONREI MBURSABLE	0	0		0		194. 00
194. 01 07950 MOW	0	0		0		194. 01
194. 02 07951 MENTAL HEALTH	0	0		0		194. 02
194. 03 07952 ADVERTI SI NG	0	0		0 1, 459		194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	0		0 3, 263		l .
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0		0 430		194. 05
194. 08 07957 MGH SMMP BLDG	0	0		0		194. 08
194. 09 07958 MGH AMBUCARE BLDG	0	0		0		194. 09
194. 10 07959 MGH 106 LYONS BLDG	0	U		0		194. 10
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00 201. 00
1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		11 220 790	11 220 70	0 424 770		
202.00 TOTAL (sum lines 118-201)	1	11, 239, 780	11, 239, 78	0 424, 779	1, 929, 076	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

NEMBER STATE STA		Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	11/23/2015 7: LAUNDRY &	
SERIEBLE SERVICE COST CENTERS		cost center bescription	REPAI RS			PLANT	LINEN SERVICE	
1.00 001000 ENERGY FILE COSTS-SULE & FIXT		GENERAL SERVICE COST CENTERS	6.00	6. 01	6. 02	7. 00	8. 00	
5.00 0.0000 JAWINI STRATT VE & CENERAL 5.00 6	1.00							1.00
0.000 0.000 AU NTEMANCE & REPAIR IS 0 1710, 950 161, 2021 161, 2								1
0.00 DOCH CAP ENR								1
0.00 DOGODO CAPITERIA 0 161,803 161,803 2,968,304 104,275 11,001 10,001 1				170. 950				1
8.00 0.0000 LAURDRY SERVICE 0 0 0 0 32,080 104,239 8 0.0 0.0 0.0 01000 INDESCREPT NO 0 0 0 51,227 883 9.0 0.0 0.0 0000 INDESCREPT NO 0 0 0 100,077 1,161 10.0 10.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0			O		161, 803			
9.00 000000			0	0	_			1
10.00 01000 DIETARY 0			0	0	0			
13.00 01300 MURSING ADM INISTRATION 0 0 2,652 10,622 10 13.00 11.10 15.0				0				
15.00			0	0	2, 652			1
HAPATE ENT ROUTINE SERVICE COST CENTERS			-	0				1
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0	15. 00] 0	0]	6, 942	46, 360	0	15.00
31.00 03100 INTERSIVE CARE, UNIT 0 0 10,242 151,902 6,516 31.00 41.00 0400 03100 03100 0400	30. 00		l	0	36, 599	663, 935	31, 063	30.00
41.00				0				•
42.00 04.00 04.00 0 0 0 0 0 4.10 0 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 4.50 0 6.50			0	0	ı	0		•
43. 00 0300 NUMSERY 0 0 4.119 0 0 4.5 00			0	0	5, 077	143, 995		1
MICHELARY SERVICE COST CENTERS 50.00 65.00 60.0000 60.000 60.000 60.000 60.000 60.000 60.000 60.0000 60.000 60.000 60.000 60.000 60.000 60.000 60.0000 60.000 60.000 60.000 60.000 60.000 60.000 60.0000 60.000 60.000 60.000 60.000 60.000 60.000 60.0000 60.000 60.000 60.000 60.000 60.000 60.000 60.0000 60.000 60.000 60.000 60.000 60.000 60.000 60.0000 60.000 60.000 60.000 60.000 60.000 60.000 60.0000 60.0000 60.0000 60.0000 60.0000 60.0000 60.0000 6		1 1		0	4. 119	0	l .	1
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 5 51.00						1		
54 OD 05400 RADIOLOXY-DIAGNOSTIC 0 0 11,446 314,517 8,539 54,00 57.00 057000 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 057			· ·	0		531, 170		1
57.00 05700 CT SCAM 0 0 0 2, 163 22, 081 2, 160 57.00				0	_	214 517		
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 1.246 67, 438 9, 55, 00 05900 CARDIAC CATHIETERI ZATION 0 0 0 2.844 76, 482 1.388 59, 00 05000 CARDIAC CATHIETERI ZATION 0 0 0 0 0 0 0 0 0				0			1	
60 00 06000 ABDRATORY 0 0 12,861 192,434 82 60 00		05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				1
60.01 06001 08000LOCY			0	0				1
0.000 0.0000 0.0000 0.00000 0.00000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.0000000 0.00000000		l i	0	0		192, 434		1
65.00 06500 RESPIRATORY THERAPY 0 0 5.301 69,099 1.146 65.00				0		0		•
69 00 06-900 06-900 06-900 06-900 07-9000 07-90000 07-90000 07-90000 07-90000 07-90000 07-90000 07-90000 07-90000 07-90000 07-90000 07-90000 07-900000 07-900000000000000000000000000000000000			0	0	5, 301	69, 699	1, 146	•
0,991 0,990 0,99			0	0				•
17.0 07100 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				
17.2 00 07.200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	19,082		•
OUTPATEENT SERVICE COST CENTERS 0			0	0	0	0	0	1
90.00 09000 CLINIC 0 0 996 42,976 746 90.00 91.00 91.00 92.01 81.922 168,230 17,402 91.00 92.01 92.0	73. 00		0	0	0	0	0	73. 00
91.00 09100 EMERGENCY 0 0 0 18,922 168,230 17,402 91.00 92.00 92.00 09200 085ERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 92.00 92.00 92.00 92.00 085ERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 92.00 92	90 00			0	996	12 976	746	90 00
92.01 09201 09500 AMBULANCE SERVICES 0 0 6, 238 63, 022 3, 689 95. 00 09500 AMBULANCE SERVICES 0 0 6, 238 63, 022 3, 689 95. 00 09500 AMBULANCE SERVICES 0 0 6, 238 63, 022 3, 689 95. 00 09500 AMBULANCE SERVICES 0 0 113. 00 113.			·			· ·		•
OTHER REI MBURSABLE COST CENTERS O O O O O O O O O						·	·	92. 00
95.00 09500 AMBULANCE SERVICES 0 0 6, 238 63, 022 3, 689 95.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 1147, 778 2, 942, 673 103, 701 118.00 103, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701 118.00 104, 701	92. 01		0	0	0	0	0	92. 01
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 103. 701 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 161, 803 147, 778 2, 942, 673 103, 701 118. 00 190. 00 1	95 00			0	6 238	63 022	3 689	95 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	70.00		<u> </u>		0, 200	00,022	0,007	70.00
NONREI MBURSABLE COST CENTERS 190.00 1900 1FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 89 20, 441 0 190.00 192.00 19		l l						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 89 20,441 0 190. 00 192. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 02 192.02 VIS ITOR MEALS 0 9,147 0 0 0 0 192. 02 192.03 19203 GREAT BEGI INNI NGS/MATERNAL 0 0 0 0 0 0 0 192. 03 192.03 19203 GREAT BEGI INNI NGS/MATERNAL 0 0 0 0 0 0 0 192. 03 192.04 19204 LI FELI INE 0 0 0 0 0 0 0 192. 05 192.05 192.05 192.05 192.05 192.05 192.05 192.05 192.05 192.06 192.07 192.08 192.11 PARI SH NURSI NG 0 0 0 0 0 0 192. 05 192.08 192.11 PARI SH NURSI NG 0 0 0 0 0 0 192. 08 192.10 192.12 BI OTERRORI SM GRANT 0 0 0 0 0 0 192. 09 192.14 192.12 BI OTERRORI SM GRANT 0 0 0 0 0 0 192. 10 192.14 192.15 192	118.00		0	161, 803	147, 778	2, 942, 673	103, 701	118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 192. 02 19202 VI SI TOR MEALS 0 0 9, 147 0 0 0 192. 02 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 0 0 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 0 0 192. 03 19204 LI FELI NE 0 0 0 0 0 0 0 0 192. 04 192. 04 19204 LI FELI NE 0 0 0 0 0 0 0 0 192. 05 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 05 192. 08 19211 PARI SH NURSI NG 0 0 0 219 5, 190 0 192. 05 192. 09 19212 BI OTERRORI SM GRANT 0 0 0 0 0 0 0 192. 09 192. 10 19214 BREAST PUMPS 0 0 0 0 0 0 0 192. 10 192. 11 19210 MGH PHYS PRACT MGMT 0 0 0 5, 892 0 0 192. 14 19210 MGH PHYS PRACT MGMT 0 0 0 5, 892 0 0 192. 14 19216 MGH MGH MGD ONC 0 0 0 2, 690 0 0 192. 15 192. 16 19216 MGH MGH MGD ONC 0 0 0 0 0 0 192. 16 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 192. 17 192. 18 19218 MGH FAIR ME DASSOC 0 0 0 192. 17 192. 19 19219 MGH FMC SOUTH 0 0 0 0 0 0 192. 17 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19300 MGH FMC GAS CITY 0 0 0 0 0 0 0 0 0 193. 01 193. 03 19303 MGH HOSPI TALLISTS 0 0 0 0 0 0 0 0 0 0 193. 03 193. 04 19304 MGH FMC GAS CITY 0 0 0 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDI ATRI C CTR 0 0 0 0 0 0 0 0 193. 07 193. 06 19306 MGH PEDI ATRI C CTR 0 0 0 0 0 543 0 0 13 193. 06 19308 MGH FMC SWAYZEE 0 0 0 0 543 0 0 13 193. 07 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 543 0 0 13 193. 07 193. 08 19308 MGH FMC CONVERSE	190.00		0	0	89	20. 441	0	190. 00
192. 03 19203 GREAT BEGINNINGS/MATERNAL 0 0 0 0 0 0 192. 03 192. 04 19204 LIFELINE 0 0 0 0 0 0 0 192. 04 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 05 192. 05 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 05 192. 08 19211 PARI SH NURSING 0 0 0 219 5, 190 0 192. 08 192. 19 19214 BREAST PUMPS 0 0 0 0 0 0 192. 09 19212 BI OTERRORI SM GRANT 0 0 0 0 0 0 192. 10 192.14 19210 MGH PHYS PRACT MGMT 0 0 0 5, 892 0 0 192. 14 19210 MGH PHYS PRACT MGMT 0 0 0 5, 892 0 0 192. 14 192. 15 192.15 MGH MARI ON SURGEONS 0 0 0 0 0 0 0 192. 15 192. 16 192.16 MGH MGH MED ONC 0 0 0 0 0 192. 15 192. 16 192.16 MGH MGH MED ONC 0 0 0 0 0 192. 15 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 192. 18 192. 19 19219 MGH FMC SOUTH 0 0 0 0 0 0 192. 18 192. 19 19219 MGH FMC MARI ON 0 0 0 0 0 0 192. 18 192. 19 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC MARI ON 0 0 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC MARI ON 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC SOLTH 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC SOLTH 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC SOLTH 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC SOLTH 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC MARI COT 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC SOLTHWOOD 0 0 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPITALISTS 0 0 0 0 0 0 0 0 193. 03 193. 03 19303 MGH MGH MAR FAM PRACT 0 0 0 0 0 0 0 193. 03 193. 05 193.05 MGH MGH MAR FAM PRACT 0 0 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDIATRIC CTR 0 0 0 2,026 0 65 193. 06 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 0 8 193. 08 193. 08 19308 MGH FMC CONVERSE				0	0	0	0	192. 00
192. 04 19204 19204 19205 OWNED PROPERTIES			0	9, 147	0	0		
192. 05 19205 00 0 0 0 0 0 192. 05 192. 08 19211 PARI SH NURSI NG		l l	0	0	0	0		
192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 0 0 0 0 0 0 192. 09 192.10 19214 BREAST PUMPS 0 0 0 0 0 0 0 192. 10 192. 14 19210 MGH PHYS PRACT MGMT 0 0 0 5, 892 0 0 192. 14 192. 15 19215 MGH MARI ON SURGEONS 0 0 0 0 0 0 192. 14 192. 16 19216 MGH MGH MED ONC 0 0 0 0 0 0 0 192. 15 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 0 192. 16 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 0 0 0 1 1 192. 17 192. 18 19219 MGH FMC MARI ON 0 0 0 0 0 0 0 1 1 192. 18 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC GAS CITY 0 0 0 0 0 0 0 0 0 193. 01 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 0 0 0 0 0 193. 02 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 0 0 0 0 193. 03 193. 05 19305 MGH FMS SWAYZEE 0 0 0 0 543 0 13 193. 08 193. 08 19308 MGH FMC SPECIALTY PHYS 0 0 0 543 0 13 193. 08 193. 08 19308 MGH FMC SPECIALTY PHYS 0 0 0 543 0 13 193. 08 193. 08 19308 MGH FMC SPECIALTY PHYS 0 0 0 0 543 0 13 193. 08				0				
192. 10 19214 BREAST PUMPS 0 0 0 5,892 0 0 192. 14 19210 MGH PHYS PRACT MGMT 0 0 5,892 0 0 192. 14 19211 MGH MARI ON SURGEONS 0 0 0 0 0 0 0 0 0 192. 15 192. 15 192. 15 MGH MGH MED ONC 0 0 0 0 0 0 0 0 192. 16 192. 16 192. 16 192. 16 192. 16 192. 16 192. 17 192. 17 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 19 192. 19 192. 19 193. 00 193. 0			O	0	219	5, 190		
192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARI ON SURGEONS 192. 16 19216 MGH MGH MED ONC 0 0 0 0 0 0 192. 15 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 0 192. 17 192. 18 19218 MGH FAIRM MED ASSOC 0 0 0 0 0 0 0 192. 17 192. 19 19219 MGH FMC MARI ON 192. 19 19219 MGH FMC MARI ON 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC GAS CITY 0 0 0 0 0 0 0 193. 02 193. 02 19302 MGH HOSPITALISTS 0 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 0 0 0 193. 04 193. 05 19305 MGH HOSPITALISTS 0 0 0 0 0 0 0 0 0 0 193. 05 193. 06 19306 MGH PRC SWAYZEE 0 0 0 0 0 0 0 193. 05 193. 08 19308 MGH FMC CONVERSE			0	0	0	0		
192. 15			0	0	[0 5 002	0		
192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 91 192. 17 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 1,646 192. 19 19219 MGH FMC MARI ON 0 0 1,646 0 32 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 0 0 0 193. 01 193. 03 19303 MGH HOSPI TALI STS 0 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 0 193. 01 193. 05 19305 MGH FMC SWAYZEE 0 0 0 2,026 193. 08 19308 MGH FMC SONVERSE 0 0 0 543 0 13 193. 08				0				
192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 1 192. 18 192. 19 19219 MGH FMC MARI ON 0 1,646 0 32 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 193. 00 193. 01 19301 MGH FMC NORTHWOOD 0 0 0 0 0 193. 01 193. 02 19302 MGH FMC GAS CI TY 0 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPI TALI STS 0 0 0 0 0 0 193. 03 19303 MGH MGH MAR FAM PRACT 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 193. 04 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 0 193. 05 193. 05 19305 MGH PEDI ATRI C CTR 0 0 2,026 0 65 193. 06 193. 07 19307 MGH SPECI ALTY PHYS 0 0 543 0 13 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 0 8 193. 08			0	0	0	0		
192. 19 19219 MGH FMC MARI ON			0	0	0	0		
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 0 0 193. 01 193. 03 19303 MGH HOSPI TALISTS 0 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 79 193. 04 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDIATRI C CTR 0 0 2, 026 193. 07 19307 MGH SPECIALTY PHYS 0 0 543 0 13 193. 08 193. 08			0	0	1 (46	0		
193. 01 19301 MGH FMC NORTHWOOD 0 0 0 0 193. 01 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPITALISTS 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 79 193. 04 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 0 193. 05 193. 06 193. 06 193. 06 193. 06 193. 07 193.07 MGH SPECIALTY PHYS 0 0 543 0 13 193. 07 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 8 193. 08				0	1, 646 0	0		
193. 03 19303 MGH HOSPI TALISTS 0 0 0 0 0 193. 03 19303 MGH HOSPI TALISTS 0 0 0 0 0 79 193. 04 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDI ATRI C CTR 0 0 0 2, 026 0 65 193. 06 193. 07 19307 MGH SPECI ALTY PHYS 0 0 543 0 13 193. 07 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 8 193. 08				Ö	Ö	Ö		
193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 79 193. 04 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDIATRIC CTR 0 0 0 2, 026 0 65 193. 06 193. 07 19307 MGH SPECIALTY PHYS 0 0 543 0 13 193. 07 193. 08 19308 MGH FMC CONVERSE 0 0 0 8 193. 08			0	0	0	0		
193. 05			0	0	0	0		
193. 06 19306 MGH PEDIATRIC CTR 0 0 2, 026 0 65 193. 06 193. 07 19307 MGH SPECIALTY PHYS 0 0 543 0 13 193. 07 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 8 193. 08				0	0	0		
193. 07 19307 MGH SPECIALTY PHYS 0 0 543 0 13 193. 07 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 8 193. 08				0	2, 026	Ö		
	193. 07	19307 MGH SPECIALTY PHYS	0	0	543		13	193. 07
173. U7 17307 WIGH OF LAND REALTR U U U U 103 193. U9			-	0	_	0		
	173.09	ALL A SO A MIGHT OF EARLY TIEMETH	<u>ı</u>	U	<u> </u>	1 0	103	1173.09

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MARION GENERAL HOSPITAL

| Peri od: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared: | 11/23/2015 7:14 am Provider CCN: 150011

					11/23/2015 7:	<u> 14 am </u>
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6. 01	6. 02	7. 00	8. 00	
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193.11 19311 MGH MGH PSYCHLATRY	0	0	262	0	0	193. 11
193. 12 19312 OB/GYN	0	0	0	0	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	194. 00
194. 01 07950 MOW	0	0	0	0	0	194. 01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	658	0	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	46	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	170, 950	161, 803	2, 968, 304	104, 239	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011

CONTROLLED PROPERTY PROPERTY PROPERTY					To	06/30/2015	Date/Time Pre 11/23/2015 7:	
Filtred SPENCET COST CENTERS 9,00 10,00 13,00 14,00 15,00		Cost Center Description	HOUSEKEEPI NG	DI ETARY		SERVICES &		14 diii
0.0100 NEW CAPP REL COSTS -BLUCA & FIXT 0.0000 AUMIN STRATICA & GEREAUL			9.00	10.00	13.00		15. 00	
INDITECT NOTITIVE SERVICE COST CENTERS 11,412 194, 126 15,217 36,679 0.30 31.00 0.3100 DAILTS & PETRIATRIC S 41,245 194,126 15,217 36,679 0.30 31.00 0.3100 DAILTS & PETRIATRIC S 41,245 194,126 15,217 36,679 0.30 0.40 0.40 0.00 0.00 0.00 0.40 0	4. 00 5. 00 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00601 CAFETERIA 00602 CAFETERIA 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2, 844 889 4, 444	0	63, 018 0	127, 511		1. 00 4. 00 5. 00 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00
30.00 30000 ADULTS & PEDIATRICS 41,245 194,126 15,217 36,979 0 30 30 30 30 30 30 30	15.00		2, 844	0	2, 886	U _I	236, 412	15. 00
50.00	31. 00 40. 00 41. 00 42. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	11, 377 0 9, 955 0	33, 828 0 32, 616 0	4, 258 0 2, 111 0	12, 751 0	0 0 0 0	30. 00 31. 00 40. 00 41. 00 42. 00 43. 00
51 0.0	50 00		20 15/	0	3 340	21 677	0	50.00
60.00 0-0000 LABORATORY 9,955 0 5,939 6,376 0 60	51. 00 54. 00 57. 00 58. 00	05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 8, 889 533 0	0	0 5, 041 899 519	0 2, 550 0 0	0 0 0 0	50. 00 51. 00 54. 00 57. 00 58. 00 59. 00
69.00 06900 CLEUTROCARD OLOGY 4, 800	60. 00 60. 01 60. 02 65. 00	06000 LABORATORY 06001 ONCOLOGY 06002 RADIATION ONCOLOGY 06500 RESPIRATORY THERAPY	9, 955 0 0 7, 466	0 0 0	5, 939 2, 016 0 2, 430	6, 376 319 0	0 0 0	60. 00 60. 01 60. 02 65. 00 66. 00
99. 00 09000 CLI NI C 3,555 0 414 0 0 97 97 00 09100 DEBRECENCY 39,821 3,601 7,867 14,026 0 97 97 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 97 07 07 07 07 07 07 07	69. 00 69. 01 71. 00 72. 00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	4, 800 5, 333 0	0 0 0 0 0	1, 563 244 0 0	0 0 0	0 0 0 0	69. 00 69. 01 71. 00 72. 00 73. 00
95. 00	91. 00 92. 00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	39, 821	3, 601	7, 867	-	0	90. 00 91. 00 92. 00 92. 01
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 1300 INTEREST EXPENSE 113.00 1300 INTEREST EXPENSE 113.00 1300 SUBTOTALS (SUM OF LINES 1-117) 187,903 264,171 62,733 108,576 236,412 113.00 1900 1910 1900 1910 1900 1910 1	95. 00		1, 244	0	2, 594	1, 275	0	95. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 356 0 0 0 0 0 0 190 191 190 192 192 00 19200 PHYSIC IANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 192 192 192 192 191 192 191 192 191 192 191 192 191 192 191 192 191 192 191 192 191 19301 19301 19301 19301 1930 1930 1	113. 00	SPECIAL PURPOSE COST CENTERS 0 11300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1-117)						113. 00
193. 07 19307 MGH SPECIALTY PHYS 0 0 0 0 0 193	192. 00 192. 01 192. 0 192. 0 192. 0 192. 0 192. 1 192. 1 192. 1 192. 1 192. 1 193. 0 193. 0 193. 0 193. 0 193. 0 193. 0	19200	0 0 0 711 356 0 0 1,422	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	0 2, 550 0 2, 550 0 319 1, 275 0 3, 825 319	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. 00 192. 02 192. 03 192. 04 192. 05 192. 09 192. 10 192. 15 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01 193. 02 193. 03 193. 04 193. 05 193. 07

Provider CCN: 150011

					11/23/2015 7:14 am	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	9. 00	10.00	13. 00	14.00	15. 00	
193.09 19309 MGH UPLAND HEALTH	0	0	0	2, 550	0 193. 0	9
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0	0 193. 10	0
193. 11 19311 MGH MGH PSYCHLATRY	0	0	0	0	0 193. 1	1
193. 12 19312 OB/GYN	0	0	0	0	0 193. 12	2
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0 193. 1!	5
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0 194. 00	0
194. 01 07950 MOW	0	37, 296	0	0	0 194. 0	1
194.02 07951 MENTAL HEALTH	0	24, 539	0	0	0 194. 0	2
194. 03 07952 ADVERTI SI NG	0	0	0	0	0 194. 0	3
194.04 07953 MGH WORK SOLUTIONS	0	0	0	1, 275	0 194. 0	4
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0 194. 0	5
194.08 07957 MGH SMMP BLDG	0	0	0	0	0 194. 0	8
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0 194. 0	9
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0 194. 10	0
200.00 Cross Foot Adjustments					200. 00	0
201.00 Negative Cost Centers	0	0	0	o	0 201. 00	0
202.00 TOTAL (sum lines 118-201)	197, 859	326, 006	63, 018	127, 511	236, 412 202. 00	0

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011

				Ť	o 06/30/2015 Date/Time Pr 11/23/2015 7	
	Cost Center Description	Subtotal	Intern &	Total	11/23/2013 /	. 14 aiii
			Residents Cost			
			& Post Stepdown			
			Adjustments			
	CENEDAL CEDULCE COCT CENTEDO	24. 00	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
6.00	00600 MAINTENANCE & REPAIRS					6. 00
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A					6. 01 6. 02
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 13. 00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON					10. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	2, 645, 317		2, 645, 317		30.00
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	627, 678	0	627, 678		31. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	539, 778		539, 778		41. 00
42. 00	04200 SUBPROVI DER	C	0	0		42. 00
43.00	04300 NURSERY	37, 181	0	37, 181		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 870, 001	l	1, 870, 001		50.00
51. 00	05100 RECOVERY ROOM	1,870,001	0	1, 870, 001		51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 109, 787	0	1, 109, 787		54. 00
57. 00	05700 CT SCAN	97, 219	1	97, 219		57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	219, 495 291, 924	l I	219, 495 291, 924		58. 00 59. 00
60.00	06000 LABORATORY	768, 110		768, 110		60.00
60. 01	06001 ONCOLOGY	44, 975	- 1	44, 975		60. 01
60. 02	06002 RADIATION ONCOLOGY	C	0	0		60. 02
65. 00	06500 RESPIRATORY THERAPY	290, 127	0	290, 127		65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	107, 005 405, 617	0	107, 005 405, 617		66. 00 69. 00
	06901 CARDI AC REHAB	70, 412	1	70, 412		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		0		71. 00
72.00	07200 NPL. DEV. CHARGED TO PATIENTS	220,020	1	330,030		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	329, 020	0	329, 020		73. 00
90.00	09000 CLINIC	146, 977	0	146, 977		90.00
91. 00	09100 EMERGENCY	757, 766	1	757, 766		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0		92.00
92. 01	O9201 OBSERVATION BEDS (DISTINCT PART)	C	0	0		92. 01
95.00	09500 AMBULANCE SERVI CES	240, 009	0	240, 009		95. 00
	SPECIAL PURPOSE COST CENTERS					
113. 00 118. 00	11300 INTEREST EXPENSE	10, 598, 398	0	10, 598, 398		113. 00 118. 00
110.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	10, 596, 396	ų ų	10, 596, 596		110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	63, 584	0	63, 584		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	C		0		192. 00
	19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL	9, 147 4, 844	l I	9, 147 4, 844		192. 02 192. 03
	19204 LI FELI NE	4, 044	l I	4, 644		192. 03
	19205 OWNED PROPERTIES	5, 839	I - I	5, 839		192. 05
	19211 PARISH NURSING	18, 391		18, 391		192. 08
	19212 BIOTERRORISM GRANT 19214 BREAST PUMPS	369	l I	369 0		192. 09 192. 10
	19210 MGH PHYS PRACT MGMT	46, 173	1 -1	46, 173		192. 10
	19215 MGH MARION SURGEONS	47, 724		47, 724		192. 15
	19216 MGH MGH MED ONC	15, 669	l I	15, 669		192. 16
	19217 MGH FMC SOUTH	59, 806	l I	59, 806		192. 17
	19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION	5, 932 18, 611	l I	5, 932 18, 611		192. 18 192. 19
	19300 NONPALD WORKERS	10,011		0,011		193. 00
	19301 MGH FMC NORTHWOOD	18, 420		18, 420		193. 01
	19302 MGH FMC GAS CITY	14, 731		14, 731		193. 02
	19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	43, 432 50, 345		43, 432 50, 345		193. 03 193. 04
	19305 MGH FMC SWAYZEE	4, 361		4, 361		193. 05
	19306 MGH PEDIATRIC CTR	25, 582		25, 582		193. 06

| Peri od: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared: Provider CCN: 150011

			10	o 06/30/2015 Date/Time Prepared: 11/23/2015 7:14 am
Cost Center Description	Subtotal	Intern &	Total	1172372013 7. 14 dill
, , , , , , , , , , , , , , , , , , ,		Residents Cost		
		& Post		
		Stepdown		
		Adjustments		
	24. 00	25. 00	26.00	
193.07 19307 MGH SPECIALTY PHYS	7, 067	0	7, 067	193. 07
193.08 19308 MGH FMC CONVERSE	6, 836	0	6, 836	193. 08
193.09 19309 MGH UPLAND HEALTH	29, 388	0	29, 388	193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	5, 035	0	5, 035	193. 11
193. 12 19312 OB/GYN	43, 769	0	43, 769	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	194. 00
194. 01 07950 MOW	37, 296	0	37, 296	194. 01
194.02 07951 MENTAL HEALTH	24, 539	0	24, 539	194. 02
194. 03 07952 ADVERTI SI NG	6, 697	0	6, 697	194. 03
194. 04 07953 MGH WORK SOLUTIONS	19, 366	0	19, 366	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	3, 142	0	3, 142	194. 05
194.08 07957 MGH SMMP BLDG	4, 229	0	4, 229	194. 08
194.09 07958 MGH AMBUCARE BLDG	965	0	965	194. 09
194.10 07959 MGH 106 LYONS BLDG	93	0	93	194. 10
200.00 Cross Foot Adjustments	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	11, 239, 780	0	11, 239, 780	202. 00

	Financial Systems	MARTUN GENERA		0011 450044 5		eu of Form CMS	
COST	ILLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 07/01/2014 To 06/30/2015	Worksheet B-1 Date/Time Pre 11/23/2015 7:	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
	T	1.00	4. 00	5A	5. 00	6. 00	
4 00	GENERAL SERVICE COST CENTERS	0.7.054		1	1		
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	367, 851 13, 902	40 170 004				1. 00 4. 00
5.00	OO4OO	60, 710	48, 179, 924 8, 403, 185	l .	124, 978, 761		5.00
6.00	00600 MAI NTENANCE & REPAI RS	00,710	0, 403, 103	-20, 710, 290	0	293, 239	6. 00
6. 01	00601 CAFETERI A	4, 842	0	d	1, 490, 196		1
6.02	00602 CAFETERI A	0	0	C	0	0	6. 02
7.00	00700 OPERATION OF PLANT	92, 792	496, 592	C	8, 102, 204		
8.00	00800 LAUNDRY & LINEN SERVICE	2, 114	0	C	490, 146		1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 382 6, 786	0		2, 650, 877 756, 559		1
13. 00	01300 NURSING ADMINISTRATION	700	810, 677		1		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 384	164, 205			l e	1
15.00	01500 PHARMACY	3, 055	2, 351, 906	C	4, 100, 890	3, 055	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDI ATRI CS	43, 752	7, 725, 782	l .			1
31. 00 40. 00	03100 INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	10, 010	2, 483, 795	C		10, 010	1
41. 00	04100 SUBPROVI DER - I RF	9, 489	1, 047, 879		-	1	1
42. 00	04200 SUBPROVI DER	0	0	ď		0	1
43.00	04300 NURSERY	0	876, 659	c	1, 530, 313	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	35, 003	1, 652, 056	1			1
51. 00 54. 00	O5100 RECOVERY ROOM O5400 RADI OLOGY-DI AGNOSTI C	0 20, 726	2, 456, 147			0 20, 726	
57. 00	05700 CT SCAN	1, 521	448, 053	l .	1, 163, 467	1, 521	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 444	258, 425	l .			
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 040	622, 844	1	2, 878, 675	l	1
60.00	06000 LABORATORY	12, 681	2, 498, 243	C	8, 484, 969	12, 681	60.00
60. 01	06001 ONCOLOGY	0	1, 019, 771	C	2, 114, 971	0	
60. 02	06002 RADI ATI ON ONCOLOGY	4 500	1 252 004		0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 593 881	1, 352, 884 1, 636, 774	1	2, 902, 783 2, 847, 244		1
69. 00	06900 ELECTROCARDI OLOGY	7, 987	738, 653	1		l	1
69. 01	06901 CARDI AC REHAB	1, 297	122, 320	1	249, 331	1, 297	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	C	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	ı c		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS] 0]	0	<u> </u> C	5, 999, 849	0	73. 00
90 00	09000 CLINIC	2, 832	260, 098	C	613, 188	2 832	90.00
	09100 EMERGENCY	11, 086	4, 019, 408	1			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C	0	0	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS	4 450	000 211		1 710 001	4 452	05 00
95.00	O9500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	4, 153	980, 311	C	1, 710, 921	4, 153	95. 00
113.00	11300 INTEREST EXPENSE						113. 00
118.00		366, 162	42, 426, 667	-26, 710, 290	99, 148, 227	291, 550	
	NONREI MBURSABLE COST CENTERS				_		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 347	20, 886		·		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS	0	0	C			192. 00 192. 02
	19202 VISITOR MEALS	0	147, 119	l .			192. 02
	19204 LI FELI NE	o o	0				192. 04
	19205 OWNED PROPERTIES	O	0	d	332, 219	0	192. 05
	19211 PARI SH NURSI NG	342	41, 990	C	98, 568		192. 08
	19212 BI OTERRORI SM GRANT	0	16, 492	1	.,		192. 09
	19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT	0	999, 897		_		192. 10 192. 14
	19215 MGH MARION SURGEONS		403, 987	1		0	192. 14
	19216 MGH MGH MED ONC	ő	0				192. 16
192. 17	19217 MGH FMC SOUTH	O	718, 342	c			192. 17
	19218 MGH FAIRM MED ASSOC	0	63, 141		348, 181	l .	192. 18
	19219 MGH FMC MARION	0	197, 649	1			192. 19
	19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD		0 266, 147		-		193. 00 193. 01
	19301 MGH FMC NORTHWOOD		266, 147 159, 638				193. 01
193. 03	19303 MGH HOSPITALISTS	0	64, 046	l .			193. 02
	19304 MGH MAR FAM PRACT	0	726, 311	l .			193. 04
		·					

Provider CCN: 150011

			To	06/30/2015	Date/Time Pre 11/23/2015 7:	
Cost Center Description	CAPITAL RELATED COSTS NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		14 (111)
oust deliter bescription	FLXT	BENEFITS	Reconciliation	& GENERAL	REPAI RS	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
	FEET)	(GROSS		COST)	FEET)	
	1221)	SALARI ES)		0001)	1221)	
	1. 00	4. 00	5A	5. 00	6. 00	
193. 05 19305 MGH FMC SWAYZEE	0	70, 855	0	221, 378		193. 05
193. 06 19306 MGH PEDIATRIC CTR	0	245, 650	0	1, 360, 912		193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	76, 749		377, 959		193. 07
193.08 19308 MGH FMC CONVERSE	0	114, 857		356, 052		193. 08
193.09 19309 MGH UPLAND HEALTH	0	359, 079	0	1, 523, 127		193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	46, 954	0	282, 435		193. 11
193. 12 19312 OB/GYN	0	429, 051	0	2, 590, 624		193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
194.00 07963 OTHER NONREI MBURSABLE	0	0	0	0		194. 00
194. 01 07950 MOW	0	0	0	0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	0	0	0		194. 02
194. 03 07952 ADVERTI SI NG	0	165, 532	2 0	296, 756	0	194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	370, 064	0	957, 683	0	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	48, 821	0	175, 695	0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	274, 017	0	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	62, 490	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	6, 014	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	11, 239, 780	26, 205, 799		26, 710, 290	0	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	30. 555252	0. 543915	5	0. 213719	0.000000	203. 00
204.00 Cost to be allocated (per Wkst. B,		424, 779	y	1, 929, 076	0	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 008817	1	0. 015435	0. 000000	205. 00
)						

	Financial Systems	MARION GENERA				u of Form CMS-:	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2014 o 06/30/2015	Worksheet B-1 Date/Time Pre	pared:
	Cost Center Description	CAFETERIA (MEALS SERVED)	CAFETERI A (HOURS WORKED)	OPERATION OF PLANT (SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	11/23/2015 7: HOUSEKEEPI NG (HOURS OF SERVI CE)	14 am
		6. 01	6. 02	FEET) 7. 00	LAUNDRY) 8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00 5. 00 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00601 CAFETERIA 00602 CAFETERIA 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	240, 915 228, 025 0 0 0 0 0	1, 316, 638 29, 175 0 0 21, 577 9, 145 56, 489	195, 605 2, 114 3, 382 6, 786 700 2, 384	703, 632 15, 408 7, 827 0 7, 973	57, 876 832 260 1, 300 832	10. 00 13. 00 14. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		207 010	42.752	200 (77	12.0/4	1 20 00
30. 00 31. 00 40. 00 41. 00 42. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0 0 0 0 0	297, 810 83, 341 0 41, 317 0 33, 514	10, 010 0 9, 489 0	43, 982 0 23, 365 0	12, 064 3, 328 0 2, 912 0	31. 00 40. 00 41. 00 42. 00
50.00	05000 OPERATING ROOM	0	65, 362	35, 003	123, 607	8, 528	
51. 00 54. 00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	93, 136	0 20, 726		2 600	
54.00	05700 CT SCAN	0	93, 136 17, 604			2, 600 156	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10, 153	4, 444	62	0	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	23, 145			1, 040	1
60. 00 60. 01	06001 ONCOLOGY	0	104, 654 0	12, 681 0		2, 912 0	1
60. 02	06002 RADIATION ONCOLOGY	0	Ō	Ö	0,777	0	60. 02
65. 00	06500 RESPI RATORY THERAPY	0	43, 136			2, 184	1
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	25, 285 30, 050			0 1, 404	
69. 01	06901 CARDI AC REHAB	0	4, 777	1, 297		1, 560	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	O	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
90.00	09000 CLI NI C	0	8, 104	2, 832	5, 033	1, 040	90.00
91. 00	09100 EMERGENCY	0	153, 970	11, 086	117, 468	11, 648	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 00 92. 01
92.01	OTHER REIMBURSABLE COST CENTERS	ı o	0		l o		92.01
95. 00	09500 AMBULANCE SERVICES	0	50, 763	4, 153	24, 899	364	95. 00
112 00	SPECIAL PURPOSE COST CENTERS				I		1112 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	228, 025	1, 202, 507	193, 916	699, 994	54 964	113. 00 118. 00
	NONREI MBURSABLE COST CENTERS		.,,				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	728 0	1, 347 0			190. 00 192. 00
	19200 PHTSI CTANS PRIVATE OFFICES	12, 890	0				192. 00
192. 03	19203 GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192. 03
	19204 LI FELI NE	0	0	0	-		192.04
	19205 OWNED PROPERTIES 19211 PARISH NURSING	0	0 1, 782	0 342	ı		192. 05 192. 08
	19212 BI OTERRORI SM GRANT	0	0	0			192. 09
	19214 BREAST PUMPS	0	0	0			192. 10
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	0	47, 946	0	0		192. 14 192. 15
	19216 MGH MGH MED ONC	0	21, 887 0		0		192. 15
192. 17	19217 MGH FMC SOUTH	0	0	0	616	2, 080	192. 17
	19218 MGH FAIRM MED ASSOC	0	12 205	0	_	0	192. 18
	19219 MGH FMC MARION 19300 NONPAID WORKERS	0	13, 395 0	0	217		192. 19 193. 00
	19301 MGH FMC NORTHWOOD	0	0	Ö			193. 01
193. 02	19302 MGH FMC GAS CITY	0	0	0	269	0	193. 02
	19303 MGH HOSPI TALI STS	0	0	0	-		193. 03 193. 04
	19304 MGH MAR FAM PRACT 19305 MGH FMC SWAYZEE		0		531 0		193. 04
193.06	19306 MGH PEDIATRIC CTR	0	16, 484	O	441	0	193. 06
193. 07	19307 MGH SPECIALTY PHYS	0	4, 418	0	90	0	193. 07

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150011

Cost Center Description CAFETERIA CAFETERIA OPERATION OF LAUNDRY & HOUSEKEEPING (MEALS SERVED) (HOURS PLANT LINEN SERVICE (HOURS OF	
WORKED) (SQUARE (POUNDS OF SERVICE)	
FEET) LAUNDRY)	
6.01 6.02 7.00 8.00 9.00	
	3. 08
193. 09 19309 MGH UPLAND HEALTH 0 0 0 1, 099 0 15	3. 09
193.10 19310 MGH MGH WOMENS CTR 0 0 0 0 0 193.10 193	3. 10
193.11 19311 MGH MGH PSYCHLATRY 0 2,134 0 0 0 19	3. 11
193. 12 19312 OB/GYN O O O O O O	3. 12
193. 15 19315 MGH RI VER VI EW BLDG 0 0 0 0 0 193.	3. 15
194. 00 07963 OTHER NONREI MBURSABLE 0 0 0 0 0 194.	4. 00
194. 01 07950 MOW 0 0 0 0 0 194.	4. 01
194. 02 07951 MENTAL HEALTH 0 0 0 0 0 191	4. 02
194. 03 07952 ADVERTI SI NG 0 5, 357 0 0 0 194.	4. 03
194. 04 07953 MGH WORK SOLUTIONS 0 0 0 311 0 19	4. 04
194. 05 07954 MGH TAYLOR UNI VERSI TY 0 0 0 0 0 194.	4. 05
194.08 07957 MGH SMMP BLDG 0 0 0 0 194.08	4. 08
194. 09 07958 MGH AMBUCARE BLDG 0 0 0 0 194.	4. 09
194.10 07959 MGH 106 LYONS BLDG 0 0 0 0 194.10	4. 10
200.00 Cross Foot Adjustments 20	0.00
201.00 Negative Cost Centers 20	1. 00
202.00 Cost to be allocated (per Wkst. B, 1,808,679 1,711,907 9,871,733 701,589 3,403,465 20	2. 00
Part I)	
203.00 Unit cost multiplier (Wkst. B, Part I) 7.507540 1.300211 50.467693 0.997096 58.806155 20	3. 00
204.00 Cost to be allocated (per Wkst. B, 170,950 161,803 2,968,304 104,239 197,859 20	4. 00
Part II)	
205.00 Unit cost multiplier (Wkst. B, Part 0.709586 0.122891 15.174990 0.148144 3.418671 20	5. 00

Health Financial Systems	MARION GENER				eu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2014	Worksheet B-1
			To		
Coot Contan Decemintion	DIETADY	NUDCLNC	CENTRAL	DUADMACY	11/23/2015 7:14 am
Cost Center Description	DI ETARY (MEALS	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY (COSTED	
	SERVED)	ADMINI STRATTON	SUPPLY	REQUIS.)	
	,	(DI RECT	(COSTED	,	
	10.00	NRSING HRS)	REQUIS.)	45.00	
GENERAL SERVICE COST CENTERS	10.00	13.00	14. 00	15. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
6.00 00600 MAI NTENANCE & REPAI RS					6.00
6. 01 00601 CAFETERI A 6. 02 00602 CAFETERI A					6. 01
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	92, 796	1			10.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY			10, 000		13.00
15. 00 01500 PHARMACY		1	0	1, 000	
INPATIENT ROUTINE SERVICE COST CENTERS				·	
30. 00 03000 ADULTS & PEDIATRICS	55, 257	1	2, 900	0	
31. 00 03100 INTENSIVE CARE UNIT	9, 629	1	1, 000	0	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	9, 284	1 "1	0 200	0	'*' **
42. 00 04200 SUBPROVI DER	7, 204	1	0	0	
43. 00 04300 NURSERY	d		0	0	
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	C	1	1, 700	0	l .
51.00 05100 RECOVERY ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC		1	0 200	0	
57. 00 05700 CT SCAN		17, 604	0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	10, 153	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	1 20,	200	0	
60. 00 06000 LABORATORY 60. 01 06001 ONCOLOGY		116, 242	500	0	60.00
60. 01 06001 0NCOLOGY 60. 02 06002 RADI ATI ON ONCOLOGY		1	25 0	0	60.01
65. 00 06500 RESPIRATORY THERAPY		1 -1	550	Ö	65. 00
66. 00 06600 PHYSI CAL THERAPY	C	48, 926	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	C	30, 595	40	0	69. 00
69.01 06901 CARDI AC REHAB 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		4, 777 0	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1	0	1, 000	
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	(0	0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 025	153, 970	1, 100	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0	0	
OTHER REIMBURSABLE COST CENTERS		,		<u> </u>	72101
95. 00 09500 AMBULANCE SERVICES	C	50, 763	100	0	95. 00
SPECIAL PURPOSE COST CENTERS					110.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117)	75, 195	1, 227, 808	8, 515	1, 000	113. 00 118. 00
NONREI MBURSABLE COST CENTERS	75, 175	1,227,000	0, 515	1,000	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	0	0	
192. 02 19202 VISITOR MEALS 192. 03 19203 GREAT BEGINNINGS/MATERNAL			0	0	192. 02
192. 04 19204 LI FELI NE			0	0	192. 03 192. 04
192. 05 19205 OWNED PROPERTIES		ol ol	0	o	192. 05
192.08 19211 PARISH NURSING	C	5, 587	0	0	192. 08
192. 09 19212 BI OTERRORI SM GRANT	C	0	0	0	192. 09
192. 10 19214 BREAST PUMPS			0	0	192. 10 192. 14
192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARION SURGEONS			285	0	192. 14
192. 16 19216 MGH MGH MED ONC		ol ol	0	Ö	192. 16
192.17 19217 MGH FMC SOUTH	C	o	200	0	192. 17
192. 18 19218 MGH FAIRM MED ASSOC	C	0	0	0	192. 18
192. 19 19219 MGH FMC MARION 193. 00 19300 NONPALD WORKERS			200 0	0	192. 19 193. 00
193. 00 19300 NONPALD WORKERS 193. 01 19301 MGH FMC NORTHWOOD			25	0	193. 00
193. 02 19302 MGH FMC GAS CITY		ol ol	100	ol	193. 02
193. 03 19303 MGH HOSPI TALI STS	0	0	0	o	193. 03
193. 04 19304 MGH MAR FAM PRACT	0	이	300	0	193. 04
193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDIATRIC CTR		1	25 25	0	193. 05 193. 06
170. 00 17000 mon EDIATRIC CIR	1	<u>'1</u>	25	U _I	[173.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1
				rom 07/01/2014	
			7	To 06/30/2015	
Cost Center Description	DI ETARY	NURSI NG	CENTRAL	PHARMACY	11/23/2015 7:14 am
cost center bescriptron		ADMI NI STRATI ON		(COSTED	
	SERVED)	ADMINI STRATION	SUPPLY	REQUIS.)	
	JLKVLD)	(DI RECT	(COSTED	REQUIS.)	
		NRSING HRS)	REQUIS.)		
	10.00	13.00	14. 00	15. 00	
193. 07 19307 MGH SPECIALTY PHYS	0	0	(0	193. 07
193.08 19308 MGH FMC CONVERSE	0	0	25	0	193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	200	0	193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0	193. 11
193. 12 19312 OB/GYN	0	0	(0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	(0	193. 15
194.00 07963 OTHER NONREI MBURSABLE	0	0	(0	194. 00
194. 01 07950 MOW	10, 616	0	(0	194. 01
194. 02 07951 MENTAL HEALTH	6, 985	0	(0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	(0	194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	0	100	0	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	(0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	(0	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	(0	194. 09
194. 10 07959 MGH 106 LYONS BLDG	0	0	(0	194. 10
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B,	1, 317, 455	1, 676, 374	1, 026, 016	5, 330, 659	202. 00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 197325	l .			
204.00 Cost to be allocated (per Wkst. B,	326, 006	63, 018	127, 511	236, 412	204. 00
Part II)	0 510147	0.051000	10 751100	224 412000	205 00
205.00 Unit cost multiplier (Wkst. B, Part	3. 513147	0. 051093	12. 751100	236. 412000	205. 00
		I	I	1	ı I

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Period: Worksheet C From 07/01/2014 Part I

					o 06/30/2015	Date/Time Pre 11/23/2015 7:	pared: 14 am
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	22, 390, 597		22, 390, 597	0	22, 390, 597	30.00
31.00	03100 INTENSIVE CARE UNIT	6, 635, 042		6, 635, 042	0	6, 635, 042	31.00
40.00	04000 SUBPROVI DER - I PF	0		0	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	4, 146, 630		4, 146, 630	0	4, 146, 630	41.00
42.00	04200 SUBPROVI DER	0		1 0	0	0	42.00
43.00	04300 NURSERY	1, 946, 496		1, 946, 496	0	1, 946, 496	43.00
	ANCILLARY SERVICE COST CENTERS		l	,		, , , , , ,	
50.00	05000 OPERATI NG ROOM	16, 439, 540		16, 439, 540	0	16, 439, 540	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 699, 122		9, 699, 122	0	9, 699, 122	54.00
57.00	05700 CT SCAN	1, 559, 412		1, 559, 412	0	1, 559, 412	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 211, 742		1, 211, 742		1, 211, 742	
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 900, 834		3, 900, 834		3, 900, 834	
60.00	06000 LABORATORY	11, 455, 510		11, 455, 510	0	11, 455, 510	60.00
60. 01	06001 ONCOLOGY	2, 629, 946		2, 629, 946	0	2, 629, 946	60. 01
60. 02	06002 RADI ATI ON ONCOLOGY	0		0	0	0	60. 02
65.00	06500 RESPIRATORY THERAPY	4, 068, 270	0	4, 068, 270	0	4, 068, 270	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 617, 977	0	3, 617, 977	0	3, 617, 977	66. 00
69.00	06900 ELECTROCARDI OLOGY	2, 342, 948		2, 342, 948		2, 342, 948	69. 00
69. 01	06901 CARDI AC REHAB	472, 583		472, 583		472, 583	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	12, 612, 790		12, 612, 790	0	12, 612, 790	
	OUTPATIENT SERVICE COST CENTERS	12/2/2/	<u> </u>	1=7 0 1=7 1 1 2	_	,,	1
90.00	09000 CLI NI C	974, 891		974, 891	0	974, 891	90.00
91. 00	09100 EMERGENCY	10, 840, 932		10, 840, 932		10, 840, 932	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 146, 556		4, 146, 556		4, 146, 556	1
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	1
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	2, 477, 659		2, 477, 659	0	2, 477, 659	95. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		123, 569, 477	0	123, 569, 477	0	123, 569, 477	200.00
201.00	Less Observation Beds	4, 146, 556		4, 146, 556		4, 146, 556	201.00
202.00		119, 422, 921	0				
		•	•	•	•	•	•

From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 7:14 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 17, 548, 110 17, 548, 110 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 534, 132 7, 534, 132 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 4. 139. 442 4, 139, 442 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 2, 239, 488 2, 239, 488 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 91, 220, 531 0.180218 0.000000 50.00 35, 593, 665 55, 626, 866 05100 RECOVERY ROOM 51.00 0.000000 0.000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 462, 337 20, 814, 709 22, 277, 046 0.435386 0.000000 54.00 57.00 05700 CT SCAN 4, 235, 059 31, 936, 324 36, 171, 383 0.043112 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 370, 088 3, 947, 316 3, 577, 228 0.306979 0.000000 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 2, 949, 119 6, 420, 461 9, 369, 580 0.416330 0.000000 59.00 06000 LABORATORY 2, 396, 233 9, 756, 306 12, 152, 539 0.942643 0.000000 60.00 60.00 60.01 06001 ONCOLOGY 24, 853 4, 908, 946 4, 933, 799 0.533047 0.000000 60.01 06002 RADIATION ONCOLOGY 0.000000 60.02 0.000000 60.02 65.00 06500 RESPIRATORY THERAPY 3, 047, 700 5, 604, 773 8, 652, 473 0. 470186 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 464, 757 6, 146, 749 11, 611, 506 0. 311586 0.000000 66.00 66.00 06900 ELECTROCARDI OLOGY 3, 716, 410 5, 764, 185 9, 480, 595 0.247131 0.000000 69.00 69.00 0. 597875 69.01 06901 CARDI AC REHAB 0 790, 438 790, 438 0.000000 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 0.000000 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 6.759.275 44, 709, 428 51, 468, 703 0.245057 0.000000 73 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 498, 190 498, 190 1. 956866 0.000000 90.00 91.00 09100 EMERGENCY 8,063,193 52, 475, 729 60, 538, 922 0.179074 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.686917 92.00 0 6, 036, 471 6, 036, 471 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 4, 035, 197 4, 035, 197 0.614012 0.000000 95 00

105, 543, 861

105, 543, 861

259, 102, 000

259, 102, 000

364, 645, 861

364, 645, 861

113.00

200.00

201. 00

202.00

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

11300 INTEREST EXPENSE

113.00

200.00

201.00

202.00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150011	From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared:

Title XVIII Hospital PPS Inpatient Ratio 11.00
Ratio 11.00 11.00
11.00
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 31. 00 40. 00 04000 SUBPROVIDER - IPF 40. 00 41. 00 04100 SUBPROVIDER - IRF 41. 00 04200 SUBPROVIDER 42. 00 43. 00 04300 NURSERY 43. 00
30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31.
31. 00 03100 INTENSI VE CARE UNI T 31. 00 40. 00 40. 00 41. 00 41. 00 42. 00 42. 00 43. 00 04300 NURSERY 43. 00
40. 00
41. 00
42. 00
43. 00 <u>04300 NURSERY</u> 43. 00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0. 180218 50. 00
51. 00 05100 RECOVERY ROOM 0. 000000 51. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 435386 54. 00
57. 00 05700 CT SCAN 0. 043112 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0. 306979 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 416330 59. 00
60. 00 06000 LABORATORY 0. 942643 60. 00
60. 01 06001 0NC0L0GY 0. 533047 60. 01
60. 02 06002 RADI ATI ON ONCOLOGY 0. 000000 60. 02
65. 00 06500 RESPI RATORY THERAPY 0. 470186 65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 311586 66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 247131 69. 00
69. 01 06901 CARDI AC REHAB 0. 597875 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 245057 73. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 1. 956866 90. 00
91. 00 09100 EMERGENCY 0. 179074 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 686917 92. 00
92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0.000000 92. 01
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES 0. 614012 95. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
200.00 Subtotal (see instructions) 200.00
201.00 Less Observation Beds 201.00
202. 00 Total (see instructions) 202. 00

Date/Time Prepared: 06/30/2015 11/23/2015 7:14 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 22, 390, 597 22, 390, 597 22, 390, 597 03100 INTENSIVE CARE UNIT 6, 635, 042 6, 635, 042 0 6, 635, 042 31.00 31.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 04100 SUBPROVI DER - I RF 0 41.00 4, 146, 630 4, 146, 630 41.00 4, 146, 630 04200 SUBPROVI DER 42.00 \cap 0 0 42.00 1, 946, 496 1, 946, 496 1, 946, 496 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 16, 439, 540 16, 439, 540 0 16, 439, 540 51.00 05100 RECOVERY ROOM 0 Ω 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 699, 122 9, 699, 122 0 0 0 9, 699, 122 54.00 05700 CT SCAN 1, 559, 412 1, 559, 412 1, 559, 412 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 211, 742 1, 211, 742 58.00 1, 211, 742 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 900, 834 3, 900, 834 3, 900, 834 59.00 06000 LABORATORY 11, 455, 510 11, 455, 510 11, 455, 510 60.00 0 0 0 0 0 60.00 06001 ONCOLOGY 60 01 2, 629, 946 2, 629, 946 2, 629, 946 60 01 60.02 06002 RADIATION ONCOLOGY \cap Ω 60.02 65.00 06500 RESPIRATORY THERAPY 4, 068, 270 4, 068, 270 4, 068, 270 65.00 66.00 06600 PHYSI CAL THERAPY 3, 617, 977 3, 617, 977 3, 617, 977 66.00 06900 ELECTROCARDI OLOGY 2. 342. 948 2, 342, 948 2, 342, 948 69 00 69 00 0 69.01 06901 CARDI AC REHAB 472, 583 472, 583 472, 583 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 71.00 0 o 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 12, 612, 790 73.00 12, 612, 790 12, 612, 790 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 974, 891 974, 891 0 974, 891 90.00 09100 EMERGENCY o 91 00 10, 840, 932 10, 840, 932 10, 840, 932 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 4, 146, 556 4, 146, 556 4, 146, 556 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 477, 659 2, 477, 659 2, 477, 659 95.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 123, 569, 477 123, 569, 477 0 123, 569, 477 200. 00

4, 146, 556

119, 422, 921

0

4, 146, 556

119, 422, 921

4, 146, 556 201. 00

119, 422, 921 202. 00

Less Observation Beds

Total (see instructions)

201.00 202.00

From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 7:14 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 17, 548, 110 17, 548, 110 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 534, 132 7, 534, 132 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 4. 139. 442 4, 139, 442 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 2, 239, 488 2, 239, 488 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 91, 220, 531 0.180218 0.000000 50.00 35, 593, 665 55, 626, 866 05100 RECOVERY ROOM 51.00 0.000000 0.000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 462, 337 20, 814, 709 22, 277, 046 0.435386 0.000000 54.00 57.00 05700 CT SCAN 4, 235, 059 31, 936, 324 36, 171, 383 0.043112 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 370, 088 3, 947, 316 3, 577, 228 0.306979 0.000000 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 2, 949, 119 6, 420, 461 9, 369, 580 0.416330 0.000000 59.00 06000 LABORATORY 2, 396, 233 9, 756, 306 12, 152, 539 0.942643 0.000000 60.00 60.00 60.01 06001 ONCOLOGY 24, 853 4, 908, 946 4, 933, 799 0.533047 0.000000 60.01 06002 RADIATION ONCOLOGY 0.000000 60.02 0.000000 60.02 65.00 06500 RESPIRATORY THERAPY 3, 047, 700 5, 604, 773 8, 652, 473 0. 470186 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 464, 757 6, 146, 749 11, 611, 506 0. 311586 0.000000 66.00 66.00 06900 ELECTROCARDI OLOGY 3, 716, 410 5, 764, 185 9, 480, 595 0.247131 0.000000 69.00 69.00 0. 597875 69.01 06901 CARDI AC REHAB 0 790, 438 790, 438 0.000000 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 6.759.275 44, 709, 428 51, 468, 703 0.245057 0.000000 73 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 498, 190 498, 190 1. 956866 0.000000 90.00 91.00 09100 EMERGENCY 8,063,193 52, 475, 729 60, 538, 922 0.179074 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.686917 92.00 0 6, 036, 471 6, 036, 471 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 4, 035, 197 4, 035, 197 0.614012 0.000000 95 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 259, 102, 000 200.00

105, 543, 861

105, 543, 861

259, 102, 000

364, 645, 861

364, 645, 861

201. 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150011	Peri od: Worksheet C From 07/01/2014 Part I To 06/30/2015 Date/Time Prepared:

			10 06/30/2015	11/23/2015 7:14 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - 1 PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57.00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 0NCOLOGY	0. 000000			60. 01
60. 02 06002 RADIATION ONCOLOGY	0. 000000			60. 02
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01 06901 CARDI AC REHAB	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150011	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part I Date/Time Pre 11/23/2015 7:	pared: 14 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost	ː		
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 645, 317	0	2, 645, 31	17, 598	150. 32	30.00
31.00 INTENSIVE CARE UNIT	627, 678		627, 67	78 3, 722	168. 64	31.00
40. 00 SUBPROVI DER - I PF	0	0)	0 0	0.00	40.00
41. 00 SUBPROVIDER - IRF	539, 778	0	539, 77	78 3, 240	166. 60	41.00
42. 00 SUBPROVI DER	0	0)	0	0.00	42. 00
43. 00 NURSERY	37, 181		37, 18	1, 945	19. 12	43.00
200.00 Total (lines 30-199)	3, 849, 954		3, 849, 95	26, 505		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 834	1, 027, 287	1			30.00
31.00 INTENSIVE CARE UNIT	1, 588	267, 800				31.00
40. 00 SUBPROVI DER - I PF	0	0)			40.00
41. 00 SUBPROVI DER - I RF	2, 646	440, 824				41.00
42. 00 SUBPROVI DER	0	0)			42. 00
43. 00 NURSERY	0	0)			43.00
200.00 Total (lines 30-199)	11, 068	1, 735, 911				200. 00

Health Financial Systems		MARION GENERAL HO	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITAL	COSTS	Provider CCN: 150011	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/23/2015 7:14 am
			Title XVIII	Hospi tal	PPS

				From 07/01/2014 To 06/30/2015	Part II Date/Time Pre	
					11/23/2015 7:	14 am_
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(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		T	T			
50. 00 05000 OPERATI NG ROOM	1, 870, 001	91, 220, 531	0. 02050		252, 888	50. 00
51.00 05100 RECOVERY ROOM	0	C	0.00000		0	51. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 109, 787		1		41, 898	54. 00
57.00 05700 CT SCAN	97, 219				· ·	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	219, 495		1	•	10, 338	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	291, 924		1		29, 891	59. 00
60. 00 06000 LABORATORY	768, 110				76, 455	60.00
60. 01 06001 0NC0L0GY	44, 975	4, 933, 799			111	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	C	0.00000	0	0	60. 02
65. 00 06500 RESPI RATORY THERAPY	290, 127	8, 652, 473	0. 03353	1 1, 601, 867	53, 712	65. 00
66. 00 06600 PHYSI CAL THERAPY	107, 005	11, 611, 506	0. 00921	5 1, 624, 246	14, 967	66. 00
69. 00 06900 ELECTROCARDI OLOGY	405, 617	9, 480, 595	0. 04278	4 2, 079, 217	88, 957	69. 00
69. 01 06901 CARDI AC REHAB	70, 412	790, 438	0. 08908	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0.00000	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0.00000	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	329, 020	51, 468, 703	0.00639	3, 034, 962	19, 403	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	146, 977	498, 190	0. 29502	2 0	0	90.00
91. 00 09100 EMERGENCY	757, 766	60, 538, 922	0. 01251	7 3, 795, 263	47, 505	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	489, 891	6, 036, 471	0. 08115	5 0	0	92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	C	0.00000	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	•		•			
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	6, 998, 326	329, 149, 492		30, 140, 143	642, 739	200. 00

					6.5. 0110	
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	MARION GENERA		CCN: 150011	Period:	eu of Form CMS- Worksheet D	2552-10
ALLOCATION WENT OF THE ATTENT ROOTING SERVICE OTHER TA	.55 111100011 005	13 Trovider		From 07/01/2014	Part III	
			-	To 06/30/2015		
-		Ti +I	e XVIII	Hospi tal	11/23/2015 7: PPS	14 am_
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	0	0		0	0	30. 00 31. 00
40. 00 04000 SUBPROVI DER - 1 PF	0)	0	40.00
41. 00 04100 SUBPROVI DER					0	
42. 00 04200 SUBPROVI DER	0				0	
43. 00 04300 NURSERY	0	Ö			0	
200.00 Total (lines 30-199)	0	0)	O	0	200. 00
Cost Center Description		Per Diem (col.	Inpatient	I npati ent		
	Days	5 ÷ col. 6)	Program Days	9		
				Pass-Through		
				Cost (col. 7 x col. 8)		
	6. 00	7. 00	8.00	9, 00	_	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00		
30. 00 03000 ADULTS & PEDI ATRI CS	17, 598	0.00	6, 83	4 O		30.00
31.00 03100 INTENSIVE CARE UNIT	3, 722	0.00	1, 58	8 0		31.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0.00		0 0		40. 00
41. 00 04100 SUBPROVI DER - I RF	3, 240			6 0		41. 00
42. 00 04200 SUBPROVI DER	0	0.00	1	0		42. 00
43. 00 04300 NURSERY	1, 945			0		43. 00
200.00 Total (lines 30-199)	26, 505	I	11, 06	8 0	1	200. 00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PAS		!	Period: From 07/01/2014 Fo 06/30/2015	Date/Time Pre 11/23/2015 7:	pared: 14 am
				e XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	J	
						4)	
	ANGLE ARY OFRICE COOT OFFITTED	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		1				
	05000 OPERATI NG ROOM	0	0	1	0	0	00.00
	05100 RECOVERY ROOM	0	0	1	0	0	51. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54.00
	05700 CT SCAN	0	0	1	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59. 00
	06000 LABORATORY	0	0		0	0	60.00
	06001 ONCOLOGY	0	0		0	0	60. 01
	06002 RADIATION ONCOLOGY	0	0)	0	0	60. 02
	06500 RESPI RATORY THERAPY	0	0)	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0)	0	0	66. 00
	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
	06901 CARDI AC REHAB	0	0)	0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	(0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	C		0	0	90. 00
	09100 EMERGENCY	0	0)	0	0	91. 00
	OCCOR ODCEDIATION DEDC (NON DICTINGT DADT)	1	۱ .		۰ .	1	0000

0 0

0 0

0 0

92. 01

91. 00 92. 00

95. 00 0 200. 00

Heal th	Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PAS	S Provi der		Period: From 07/01/2014 To 06/30/2015		
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total		Ratio of Cost		I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	91, 220, 531			12, 336, 015	
	05100 RECOVERY ROOM	0	0	0.00000			51. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 277, 046	•			
	05700 CT SCAN	0	36, 171, 383	•			1
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 947, 316	•		185, 912	1
	05900 CARDI AC CATHETERI ZATI ON	0	9, 369, 580	1			59. 00
60. 00	06000 LABORATORY	0	12, 152, 539	l .			60. 00
	06001 ONCOLOGY	0	4, 933, 799	l .		12, 230	l
	06002 RADI ATI ON ONCOLOGY	0	0	0.00000		-	60. 02
65. 00	06500 RESPI RATORY THERAPY	0	8, 652, 473				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	11, 611, 506				
69. 00	06900 ELECTROCARDI OLOGY	0	9, 480, 595	II.		2, 079, 217	l
69. 01	06901 CARDI AC REHAB	0	790, 438	0. 00000	0.000000	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0.000000	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	51, 468, 703	0.00000	0.000000	3, 034, 962	73. 00
	OUTDATIENT SERVICE COST CENTERS						I

0 0 0

0

0.000000

0.000000

0.000000

0.000000

0.000000

0. 000000 0. 000000

0.000000

3, 795, 263

0 92.01

30, 140, 143 200. 00

90.00

91.00

92.00 0

95.00

60, 538, 922

6, 036, 471

329, 149, 492

498, 190

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

OTHER REI MBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVI CES

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

09000 CLI NI C

91. 00 09100 EMERGENCY

200.00

Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Health Financial Systems MARION GENERAL HOSPITAL IN Lieu of Form CMS-2552-10

Provider CCN: 150011 | Period: From 07/01/2014 | Part IV To 06/30/2015 | Date/Time Prepared:

				Т	o 06/30/2015	Date/Time Pro 11/23/2015 7	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Out	pati ent	Outpati ent			
	Program	Pr	ogram	Program			
	Pass-Through	Ch	narges	Pass-Through			
	Costs (col. 8			Costs (col. 9			
	x col. 10)			x col. 12)			
	11. 00	1	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS	T			ı	T		
50. 00 05000 OPERATI NG ROOM	0	1	4, 230, 475	0			50.00
51.00 05100 RECOVERY ROOM	0		0	0			51. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		6, 258, 839				54.00
57. 00 05700 CT SCAN	0		9, 223, 094				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		1, 140, 823				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		3, 252, 392				59. 00
60. 00 06000 LABORATORY	0		1, 530, 824				60.00
60. 01 06001 0NCOLOGY	0		1, 872, 089	0			60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0		0	0			60. 02
65. 00 06500 RESPI RATORY THERAPY	0		1, 703, 704				65. 00
66. 00 06600 PHYSI CAL THERAPY	0		112	0			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0		2, 010, 881	0			69. 00
69. 01 06901 CARDI AC REHAB	0		433, 920	0			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0			72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	2	2, 201, 935	0			73. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0		216, 365				90. 00
91. 00 09100 EMERGENCY	0		0, 892, 202				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1, 247, 985	0			92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0			92. 01
OTHER REIMBURSABLE COST CENTERS	,						
95. 00 09500 AMBULANCE SERVI CES							95. 00
200.00 Total (lines 50-199)	0	7	6, 215, 640	0			200. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150011	Peri od:	Worksheet D	
				From 07/01/2014 To 06/30/2015	Part V	nonad.
				To 06/30/2015	Date/Time Pre 11/23/2015 7:	
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.			
	1.00		(see inst.)	(see inst.)		
ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.100010	14 220 475			2 5/4 500	F0 00
50. 00 05000 OPERATING ROOM	0. 180218			0	2, 564, 588	
51. 00 05100 RECOVERY ROOM	0. 000000			0	0 705 011	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 435386			0	2, 725, 011	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 043112			0	397, 626	
	0. 306979			0	350, 209	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 416330			0	1, 354, 068	
60. 00 06000 LABORATORY	0. 942643			0	1, 443, 021	
60. 01 06001 0NCOLOGY	0. 533047	1, 872, 089		0	997, 911	
60. 02 06002 RADI ATI ON ONCOLOGY 65. 00 06500 RESPI RATORY THERAPY	0. 000000	l e		0	0	60. 02
	0. 470186			0	801, 058	
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0. 311586 0. 247131			0	35 496, 951	
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0. 247131			0	259, 430	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0	259, 430	71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	l e		0 0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	0. 245057	22, 201, 935		0 23, 533	Ĭ	
OUTPATIENT SERVICE COST CENTERS	0. 243037	22, 201, 933		0 23, 333	5, 440, 740	73.00
90. 00 09000 CLINIC	1. 956866	216, 365		0	423, 397	90.00
91. 00 09100 EMERGENCY	0. 179074			0 0	1, 950, 510	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686917			0 0	857, 262	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			0	007,202	92. 01
OTHER REIMBURSABLE COST CENTERS	0.00000			<u>o</u>		72.01
95. 00 09500 AMBULANCE SERVI CES	0. 614012			0		95. 00
200.00 Subtotal (see instructions)		76, 215, 640	3, 07	0 23, 533	20, 061, 817	
201.00 Less PBP Clinic Lab. Services-Program		1]	0 0		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		76, 215, 640	3, 07	0 23, 533	20, 061, 817	202. 00

Health Financial Systems	MARION GENERAL HC	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150011	Peri od: From 07/01/2014	Worksheet D

To 06/30/2015 Date/Time Prepared: 11/23/2015 7:14 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 51.00 05100 RECOVERY ROOM 0 51.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 57.00 05700 CT SCAN 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 59.00 0 06000 LABORATORY 60.00 2,894 60.00 60.01 06001 ONCOLOGY 0 0 60.01 06002 RADIATION ONCOLOGY 0 60.02 0 0 0 0 0 0 0 60.02 06500 RESPIRATORY THERAPY 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 69.01 06901 CARDI AC REHAB 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 767 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 0 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 2, 894 200. 00 Subtotal (see instructions) 5, 767 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 2,894 5, 767 202. 00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150011	Peri od:	Worksheet D	2002 10
7 0	Totale of Tarrite and Tarrite and Tarrite of	000.0			From 07/01/2014	Part II	
			Component	CCN: 15T011	To 06/30/2015		
			T	\0.41.1	0.1	11/23/2015 7:	<u>14 am</u>
			litl	e XVIII	Subprovi der -	PPS	
	C+ C+	0: +-1	T-+-1 Ch	D-+:£ C	I RF	Capital Costs	
	Cost Center Description	Capi tal	Total Charges (from Wkst. C,		t Inpatient Program	(column 3 x	
		(from Wkst. B.				column 4)	
		Part II, col.	8)	2)	. Charges	Corumn 4)	
		26)	0)	2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	1, 870, 001	91, 220, 531	0. 02050	00 69, 650	1, 428	50.00
51. 00	05100 RECOVERY ROOM	1,070,001					1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 109, 787					54.00
57. 00	05700 CT SCAN	97, 219					1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	219, 495		l .			
59. 00	05900 CARDIAC CATHETERIZATION	291, 924		l .			
60.00	06000 LABORATORY	768, 110		l .			
60. 00	06001 ONCOLOGY	44, 975					60. 01
60. 01	06002 RADI ATI ON ONCOLOGY	44, 973					
65. 00	06500 RESPI RATORY THERAPY	290, 127	-	l .			
66. 00	06600 PHYSI CAL THERAPY	107, 005					
69. 00	06900 ELECTROCARDI OLOGY	405, 617		l .			
69. 01	06901 CARDI AC REHAB	70, 412				1, 012	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70,412	7 70, 430	0.00000		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	329, 020	51, 468, 703				
73.00	OUTPATIENT SERVICE COST CENTERS	327,020	31, 400, 703	0.0003	300, 701	2, 434	73.00
90. 00	09000 CLINIC	146, 977	498, 190	0. 29502	02	0	90.00
91. 00	09100 EMERGENCY	757, 766		l .			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		l .		0	
	09201 OBSERVATION BEDS (DISTINCT PART)	0	1			0	
,	OTHER REIMBURSABLE COST CENTERS		·	2. 23000			1
95. 00	09500 AMBULANCE SERVI CES						95. 00
200.00		6, 508, 435	329, 149, 492		3, 093, 489	36, 944	
	1 1			1	1 2/2/2/10/		, ,

	Financial Systems	MARION GENERA		۸L		In Lie	eu of Form CMS-	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Prov	⁄i der	CCN: 150011	Peri od:	Worksheet D	
THROUG	H COSTS		Come		- CCN, 1FT011	From 07/01/2014		nanad.
			Comp	onent	CCN: 15T011	To 06/30/2015	Date/Time Pre 11/23/2015 7:	
				Ti tl	e XVIII	Subprovi der -	PPS	
						IRF		
	Cost Center Description	Non Physician	Nursing S	chool	Allied Healt		Total Cost	
		Anestheti st				Medi cal	(sum of col 1	
		Cost				Education Cost		
							4)	
	ANOLULARY OFRICAS COOT OFFITTED	1.00	2.00		3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS							
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	2	0		0	0	50. 00 51. 00
		0	<u>'</u>	0		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	<u>'</u>	0		0	0	54.00
57. 00	05700 CT SCAN	0	<u>'</u>	0		0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	<u>'</u>	0		0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	<u>'</u>	0		0	0	
60.00	06000 LABORATORY	0]	0		0	0	
60. 01	06001 ONCOLOGY	0]	0		0	0	
60. 02	06002 RADI ATI ON ONCOLOGY	0	2	0		0	0	
65. 00	06500 RESPIRATORY THERAPY	0]	0		0	0	
66. 00	06600 PHYSI CAL THERAPY	0]	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0]	0		0	0	
69. 01	06901 CARDI AC REHAB	0]	0		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0]	0		0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0]	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0)	0		0 () 0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	1	J	0	Γ	0 (90.00
90.00		0	<u>'</u>	0		0 0	Ί ,	
91.00	09100 EMERGENCY	0	1	0		0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0]	0		0	0	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	1	0		0 0	0	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		T		T			05.00
			J	0				95. 00
200.00	Total (lines 50-199)	0	1	0	I	0 0	0 ار	200. 00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 07/01/2014 To 06/30/2015	Part IV Date/Time Pre	namad.
			Component	CCN: ISTOTT	10 06/30/2015	11/23/2015 7:	pareu: 14 am
			Ti tl	e XVIII	Subprovi der -	PPS	
					. I RF		
	Cost Center Description	Total	Total Charges			I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.			Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4)			7)		
	ANOLULARY OFRICAS COOT OFFITTED	6. 00	7. 00	8. 00	9. 00	10. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS		04 000 504	0.0000	0 000000	/0 /50	
50.00	05000 OPERATI NG ROOM	0				69, 650	•
51.00	05100 RECOVERY ROOM	0	0	1 0.0000		0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 277, 046			33, 335	1
57. 00	05700 CT SCAN	0	36, 171, 383			61, 718	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 947, 316			9, 997	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	9, 369, 580			2, 985	59.00
60.00	06000 LABORATORY	0	12, 152, 539			70, 065	60.00
60. 01	06001 ONCOLOGY	0	4, 933, 799			885	
60. 02	06002 RADI ATI ON ONCOLOGY	0	0 (50 470			0	
65.00	06500 RESPIRATORY THERAPY	0	8, 652, 473			85, 264	
66.00	06600 PHYSI CAL THERAPY	0	11, 611, 506			2, 303, 677	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	9, 480, 595			37, 683	
69. 01	06901 CARDI AC REHAB	0	790, 438			0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1 0.0000		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	51, 468, 703	0.00000	0.000000	380, 701	73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC		498, 190	0.00000	0.00000	0	90.00
	109100 EMERGENCY	0	60, 538, 922			37, 529	
91.00		0					1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	6, 036, 471 0	1		0	92.00
92.01	OTHER REIMBURSABLE COST CENTERS		<u> </u>	0.00000	U ₁ U. UUUUUU	0	72.01
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00		0	329, 149, 492			3, 093, 489	
200.00		1	J 27, 147, 492	I	T	3, 073, 409	₁ 200.00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PASS	Component	CCN: 150011 : CCN: 15T011	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Pro 11/23/2015 7:	epared:
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Througl Costs (col. x col. 12) 13.00	h		
	ANCILLARY SERVICE COST CENTERS				'		$\overline{}$
50.00	05000 OPERATING ROOM	0	0		0		50.00
	05100 RECOVERY ROOM	0	0		0		51.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
	05700 CT SCAN	0	0		0		57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
	06000 LABORATORY	0	0		0		60.00
	06001 ONCOLOGY	0	0		0		60. 01
	06002 RADI ATI ON ONCOLOGY	0	0		0		60. 02
	06500 RESPI RATORY THERAPY	0	0		0		65. 00
	06600 PHYSI CAL THERAPY	0	0		0		66. 00
	06900 ELECTROCARDI OLOGY	0	0		0		69. 00
	06901 CARDI AC REHAB	0	0		0		69. 01
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0		72. 00 73. 00
	OUTPATIENT SERVICE COST CENTERS	J U	0		U		73.00
	09000 CLINIC	O	0		0		90.00
	09100 EMERGENCY		0		ō		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		o		92. 00
	09201 OBSERVATION BEDS (DISTINCT PART)	o	0		Ō		92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0		0		200. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150011	Period: From 07/01/2014	Worksheet D-1	
			Date/Time Pre 11/23/2015 7:	
	Title XVIII	Hospi tal	PPS	
0 1 0 1 1 11				

			10 00,00,2010	11/23/2015 7:	14 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			11 00	
	I NPATI ENT DAYS		,		
1.00	Inpatient days (including private room days and swing-bed days,			17, 598	1.00
2.00	Inpatient days (including private room days, excluding swing-be			17, 598	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.). IT you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		14, 339	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period	3 ,			
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		21 -6	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			_	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	6, 834	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		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 only		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		dom days) arter	O	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				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14. 00
14. 00 15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT			-	
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of	the cost	0.00	18. 00
16.00	reporting period	arter becember 31 or	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	C. D. I. O. C.			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			22, 390, 597	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reporti	ng poriod (line	0	24. 00
24.00	7 x line 19)	or the cost reporti	ing period (Title	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
27 00	x line 20)			0	27, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 22, 390, 597	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 millios Title 20)		22, 370, 377	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	Tine 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		/	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	22, 390, 597	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 272. 34	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	,		8, 695, 172	
40. 00	Medically necessary private room cost applicable to the Program	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		8, 695, 172	41. 00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 150011	Peri od:	Worksheet D-1	
					From 07/01/2014 To 06/30/2015		pared:
			T: ±1	- \/\/		11/23/2015 7:	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	555 55.1.5. 5555.1.pt. 5.1	Inpatient Cost			3	(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units			0.1	50 0		1 42.00
43.00	INTENSIVE CARE UNIT	6, 635, 042	3, 722	1, 782.	66 0	0	43. 00
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	ct D 2 col 2	Lino 200)			1. 00 7, 495, 130	48. 00
	Total Program inpatient costs (sum of lines			ons)		16, 190, 302	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	n of Parts I and	1, 295, 087	50. 00
51. 00	 Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	642, 739	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				1, 937, 826	52.00
52.00	Total Program excludable cost (sum of fines) Total Program inpatient operating cost exclu		elated. non-phy	sician anesth	netist and	1, 937, 826	
00.00	medical education costs (line 49 minus line					1 1, 202, 170]
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION					1	
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	
57. 00	Difference between adjusted inpatient operat	ing cost and ta	irget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting poriod	anding 1004	indated and co	ampounded by the	0 00	58. 00 59. 00
59.00	market basket	porting period	enarng 1996, u	ipuateu anu co	ompounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60. 00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		S (Tines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	•				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
/F 00	instructions)(title XVIII only)		21 -6 +1				/ F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI				<u> </u>	I	70. 00
71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	-)		71.00
72. 00	Program routine service cost (line 9 x line			,			72. 00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital -related cost allocated to inpatient	,			Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces				aus Lino 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iiiiii täti on	וות א/ שווו) ו	ius IIIIe /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation ()				82. 00
83.00	Reasonable inpatient routine service costs (is)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		nns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				1	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			3, 259 1, 272. 34	1
	Observation bed cost (line 87 x line 88) (se	•	,			4, 146, 556	1
		- /					•

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015	Date/Time Prep 11/23/2015 7:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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 O	COST					
90.00 Capital -related cost	2, 645, 317	22, 390, 597	0. 11814	4, 146, 556	489, 891	90.00
91.00 Nursing School cost	0	22, 390, 597	0.00000	0 4, 146, 556	0	91. 00
92.00 Allied health cost	0	22, 390, 597	0.00000	0 4, 146, 556	0	92.00
93.00 All other Medical Education	0	22, 390, 597	0. 00000	0 4, 146, 556	0	93. 00

Health Financial Systems	MARION GENERAL HOS	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Worksheet D-1
		Component CCN: 15TO11	From 07/01/2014 To 06/30/2015	
		Title XVIII	Subprovi der -	PPS
			LDE	

PART ALL PROPRIETS			TI LIE AVIII	I RF	FF3	
MART - ALL PROVIDER COMPONENTS		Cost Center Description			1.00	
INVAILED TOWNS 1.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatient days (including private room days, excluding saing-bed and nekeror days) 3,240 3,00 1,00						
Drivate room days (excluding swing-bed and observation bed days). If you have only private room days (excluding swing-bed and observation bed days) through December 31 of the cost 5.00 foot and similar points of the cost 1.00 foot swing-bed SNF type inpatient days (including private room days) through December 31 of the cost 1.00 foot 1.00 foot swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1.00 foot 1.00					· ·	
do not complete this line. 4. 05 oils—private room days (excluding saing-bed and observation bed days) through becember 31 of the cost 1. 0. 5.00 (popting period) (in call endars year, enter 0 on this line). 7. 00 Total saving-bed SN type inpartient days (including private room days) after December 31 of the cost 2. 0. 6.00 reporting period (in call endar year, enter 0 on this line). 7. 00 Total saving-bed N type inpartient days (including private room days) through becember 31 of the cost 2. 0. 7. 00 reporting period (in call endar year, enter 0 on this line). 8. 00 Total saving-bed N type inpartient days (including private room days) after December 31 of the cost 2. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.						
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reporting period (if callendar year, enter 0 on this line) 7.00	4.00		days)		3, 240	4.00
10tal swingh-ed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (I're calendar year, enter 0 on this line) 7.00	5.00		days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Mi Type inpatient days (including private room days) through December 31 of the cost reporting period 8. 00 Total swing-bed Mi Type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed Mi Type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11. 00 Swing-bed SW type inpatient days applicable to till it XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed MF type inpatient days applicable to till its V or XIX only (including private room days) 13. 00 Swing-bed MF type inpatient days applicable to till its V or XIX only (including private room days) 14. 00 [Medically inecessary private room days applicable to the Program (excluding swing-bed days) 15. 00 [Total nursery days (till e V or XIX only) 16. 00 [North year year year year year year year year	6 00		days) after December 3	21 of the cost	0	6 00
1-00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 7.00	0.00		uays) arter becember s	or or the cost	U	0.00
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5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average perivate room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential (line 3 x line 35) 30.00 Private room cost differential (line 3 x line 35) 30.00 PROBLET CONDITION (Line 3 x line 36) 30.00		Total general inpatient routine service cost (see instructions)			4, 146, 630	
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x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 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) 4, 146, 630 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000003 32.00 Average private room per diem charge (line 29 + line 3) 0.00 33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630 27.00) Apart II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 279.82 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 3, 386, 404 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	1	of the cost reporting	period (line 6	0	23. 00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Average per diem private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 4, 146, 630) Average per diem private room cost differential (line 3 x line 35) Average per diem private ro		x line 18)				
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x line 20) 26. 00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem charge (line 21 x line 25) Ceneral inpatient routine service cost per diem charge (li	25. 00		of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4, 146, 630 27. 00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29. 00 29. 00 29. 00 29. 00 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00] 9	or and court repair and			
PRI VATE ROOM DIFFERENTI AL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 33.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential djustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630 and 1) 37.00 FART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.01 Program (line 14 x line 35) 30.02 Average per diem rivet room cost applicable to the Program (line 14 x line 35)		, ,	04 ' '' 04)			
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29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 20.00 30.00 0.000000 31.00 0.000 32.00 32.00 33.00 0.000 34.00 0.000 35.00 36.00 37.00 36.00 37.00 37.00 37.00 38.00 40.00 40.00	28. 00		and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630 and 19 part 11 - HOSPITAL AND SUBPROVIDERS ONLY program invasion program general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 31.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	29. 00	Private room charges (excluding swing-bed charges)				
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35. 00 Average per diem private room cost differential (line 34 x line 31) 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 and private room cost differential (line 4, 146, 630 37. 00) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 279. 82 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 3, 386, 404 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 146, 630 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 4, 146, 630 37.00 3			, ,	tions)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 4, 146, 630 4, 1		, , ,	31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 279. 82 38.00 Program general inpatient routine service cost (line 9 x line 38) 3, 386, 404 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			d private room cost dif	ferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 279. 82 38.00 Program general inpatient routine service cost (line 9 x line 38) 3, 386, 404 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	200	27 minus line 36)	,		.,	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 279. 82 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1, 279. 82 38.00 3, 386, 404 39.00 40.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3,386,404 39.00 40.00	38 00			I	1 270 92	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 3,386,404 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		3, 386, 404	41. 00

PUTATION OF INPATIENT OPERATING COST		Provi der CCN		Period: From 07/01/2014	Worksheet D-1	
		Component CC		To 06/30/2015	Date/Time Pre 11/23/2015 7:	
		Title X	VIII	Subprovi der - I RF	PPS	
Cost Center Description	Total		verage Per	Program Days	Program Cost	
	Inpatient Cost In	patient DaysDie	m (col. 1 · col. 2)	:	(col. 3 x col. 4)	
OO NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00) 42.
Intensive Care Type Inpatient Hospital Unit		<u> </u>	0.00	5 0	0	42.
DO INTENSIVE CARE UNIT DO CORONARY CARE UNIT	0	0	0.00	0	0	43.
DO BURN INTENSIVE CARE UNIT						45.
OO SURGICAL INTENSIVE CARE UNIT						46.
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
<u> </u>					1. 00	
On Program inpatient ancillary service cost (V					967, 767	
700 Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	s 41 through 48)(Se	e instructions)			4, 354, 171	49
Pass through costs applicable to Program in	npatient routine se	rvices (from Wk	st. D, sum	of Parts I and	440, 824	50
	anationt ancillary	convices (from	Nks+ D si	ım of Dorte II	24 044	
and IV)	ipatrent andfilaly	SCIVICES (IIUIII	mnsi. D, Sl	am Or FaltS II	36, 944	51
Total Program excludable cost (sum of lines					477, 768	
Total Program inpatient operating cost excl medical education costs (line 49 minus line		ted, non-physic	ian anesthe	etist, and	3, 876, 403	53
TARGET AMOUNT AND LIMIT COMPUTATION	, 02)					
Program discharges Target amount per discharge					0 0. 00	54
DO Target amount (line 54 x line 55)					0.00	
Difference between adjusted inpatient opera	ating cost and targ	et amount (line	56 minus I	ine 53)	0	
00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost r	cenorting period en	dina 1006 unda	ted and con	nnounded by the	0 0. 00	
market basket	eportring perrou en	urng 1770, upua	ted and con	iipourided by the	0.00	7 37
DO Lesser of lines 53/54 or 55 from prior year					0.00	
OO If line 53/54 is less than the lower of line which operating costs (line 53) are less the					0	61
amount (line 56), otherwise enter zero (see		,		3		
00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive pay	ment (see instruct	i one)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see mistruct	1 0113)			O O	
Medicare swing-bed SNF inpatient routine co	osts through Decemb	er 31 of the co	st reportir	ng period (See	0	64
instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	osts after December	31 of the cost	reporti ng	period (See	0	65
instructions)(title XVIII only)						
70 Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	tine costs (line 64	plus line 65)(title XVIII	only). For	0	66
Title V or XIX swing-bed NF inpatient routi	ne costs through D	ecember 31 of t	he cost rep	porting period	0	67
(line 12 x line 19)	no costo often Doo	ambar 21 of the	anat manau	ating popied	0	
OO Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after Dec	ember 31 of the	cost repor	ting period	0	68
Total title V or XIX swing-bed NF inpatient					0	69
PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci						70
Adjusted general inpatient routine service			(11110 07)			71
Program routine service cost (line 9 x line)	· ·	lino 14 v lino	25)			72
00 Medically necessary private room cost appli 00 Total Program general inpatient routine ser			<i>აა)</i>			73
OO Capital-related cost allocated to inpatient			sheet B, Pa	art II, column		75
26, line 45) 20 Per diem capital-related costs (line 75 ÷ l	ine 2)					76
Program capital-related costs (line 9 x line)						77
On Inpatient routine service cost (line 74 mir	,	vi don nocendo)				78
OO Aggregate charges to beneficiaries for exce Total Program routine service costs for con			ine 78 minu	us line 79)		79 80
OO Inpatient routine service cost per diem lim	ni tati on			/		81
On Inpatient routine service cost limitation (•					82
00 Reasonable inpatient routine service costs 00 Program inpatient ancillary services (see i						83
OO Utilization review - physician compensation	n (see instructions					85
Total Program inpatient operating costs (su		ugh 85)				86
PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					0	87
to protai observation bed days (see mistraction						

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi de	- CCN: 150011	Peri od:	Worksheet D-1	
		Compone		From 07/01/2014 To 06/30/2015		pared:
					11/23/2015 7:	
		Ti t	le XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27) 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	539, 778	4, 146, 63	0. 1301	73 0	0	90.00
91.00 Nursing School cost	0	4, 146, 63	0. 00000	00	0	91.00
92.00 Allied health cost	0	4, 146, 63	0. 00000	00	0	92.00
93.00 All other Medical Education	0	4, 146, 63	0. 00000	00	0	93.00

Health Financial Systems	MARION GENERAL HOSPITAL In Lieu			2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150011	From 07/01/2014	Worksheet D-1 Date/Time Prep 11/23/2015 7:	
	Title XIX	Hospi tal	Cost	
0 1 0 1 0 1 1				

		Title XIX	Hospi tal	11/23/2015 7: Cost	<u>14 am</u>
	Cost Center Description	TI CI C XIX	1103pi tai	0031	
	DADT I ALL DOWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		17, 598	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			17, 598	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		14, 339	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	14, 339	5. 00
0.00	reporting period	aayo, oag booobo	0. 0. 1 0001	Ü	0.00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)	da) #bb Da.ab	24 -6	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	aays) through becember	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 549	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	/ (including private r	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction)		Joil days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)				15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 or	f the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	till dagit becember 31 of	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
	reporting period			00 000 507	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost reporti	ng poriod (line	22, 390, 597 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	riig perrou (Triie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reportii	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	21 1: 2()		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus iine 26)		22, 390, 597	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		o ,	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	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)	rne 28)		0. 000000 0. 00	
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 minu	s line 33)(see instruc	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	a private room cost di	rrential (line	22, 390, 597	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 272. 34	
39.00	Program general inpatient routine service cost (line 9 x line 3	,		1, 970, 855	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			0 1, 970, 855	40. 00 41. 00
00	1.111g. a.m. gonor ar impactions routino por vivo dopt (11116 07)	,		., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	00

Heal th	Financial Systems MARION GENERAL HOSPITAL In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST Provider CCN: 150011 Period:	Worksheet D-1	
	From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:
	Title XIX Hospital	11/23/2015 7: 3	14 am_
	Cost Center Description Total Total Average Per Program Days	Cost Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷	(col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 1,946,496 1,945 1,000.77 0		42. 00
	Intensive Care Type Inpatient Hospital Units		
43.00	INTENSIVE CARE UNIT 6,635,042 3,722 1,782.66 0	0	43.00
44. 00 45. 00	BURN INTENSIVE CARE UNIT		44. 00 45. 00
46. 00			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1. 00	
48. 00		1, 132, 530	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3, 103, 385	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00
00.00			00.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	o	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	Ö	53. 00
	medical education costs (line 49 minus line 52)		
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
55. 00		0.00	
56. 00	Target amount (line 54 x line 55)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	
	market basket		
60. 00 61. 00		0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	U	01.00
	amount (line 56), otherwise enter zero (see instructions)		
62. 00 63. 00		0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	0	03.00
64. 00		0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
	instructions)(title XVIII only)		
66. 00		0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
	(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)	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		70.00
70. 00 71. 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)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
70.00	26, line 45)		70.00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81. 00 82. 00
82.00	Reasonable inpatient routine service costs (see instructions)		82.00
84. 00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00		3, 259	87. 00
88.00		1, 272. 34	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4, 146, 556	67. UU

Health Financial Systems	MARION GENERAL HOSPITAL			In Lieu of Form CMS-255		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015	Date/Time Prep 11/23/2015 7:	pared: 14 am_
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	2, 645, 317	22, 390, 597	0. 11814	4, 146, 556	489, 891	90.00
91.00 Nursing School cost	0	22, 390, 597	0.00000	0 4, 146, 556	0	91.00
92.00 Allied health cost	0	22, 390, 597	0.00000	0 4, 146, 556	0	92.00
93.00 All other Medical Education	0	22, 390, 597	0. 00000	0 4, 146, 556	0	93. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150011	Peri od: From 07/01/2014	Worksheet D-1
	Component CCN: 15T011	To 06/30/2015	Date/Time Prepared: 11/23/2015 7:14 am
	Title XIX	Subprovi der -	Cost

		TI LIE XIX	I RF	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 240	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed			3, 240	
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.). IT you have only pri	vate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 240	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
	reporting period	daya) after December 1	01 of the cost		4 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room (days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	115	9. 00
7. 00	newborn days)	the trogram (exergating	om ng bou and		7. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ento	er 0 on this line)	Join days) arter	٥	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program	· •	,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	. 5 5	,	1, 945	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through Docombor 21 of	f the cost	0.00	17. 00
17.00	reporting period	tili odgir becelliber 31 or	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost	0.00	18. 00
10.00	reporting period			2.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)	21 of the cost managet:	ng poriod (line	4, 146, 630	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	period (line 6	0	23. 00
	x line 18)			ا	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	, ,	' '		
26. 00	Total swing-bed cost (see instructions)	no 21 minuo lino 24)		0	
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus iine 20)		4, 146, 630	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	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)	ine 28)		0. 000000 0. 00	
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 minus	s line 33)(see instruct	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		S6	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	a private room cost dif	recential (IIne	4, 146, 630	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see in			1, 279. 82	
39.00	Program general inpatient routine service cost (line 9 x line 3) Medically necessary private room cost applicable to the Program	•		147, 179 0	39. 00 40. 00
40. 00 41. 00	Total Program general inpatient routine service cost (line 39 +	,		147, 179	
55	1.2.2 25. dail gono. dapac. one roderno oor vioo oost (1110 ov r		ı	117, 177	

	Financial Systems	MARION GENERAL H			In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN	Fr	eriod: com 07/01/2014	Worksheet D-1	
			Component CC			11/23/2015 7:	
			Title		Subprovi der - I RF	Cost	
	Cost Center Description	Total Inpatient Cost Inp		verage Per m (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
10.00	NUDGERY (1:11 W a WW L)	1.00	2.00	3.00	4. 00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	Cost center bescription					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines					36, 015 183, 194	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 46) (see	THSTI uctions)			103, 194	1 49.00
50. 00	Pass through costs applicable to Program inp	atient routine ser	vices (from Wk	st. D, sum c	of Parts I and	0	50.00
51. 00		atient ancillary s	ervices (from	Wkst. D, sum	of Parts II	0	51.00
	and IV)	•	•	•			
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		ed non-physic	ian anesthet	ist and	0	
	medical education costs (line 49 minus line						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ng cost and targe	t amount (line	56 minus li	ne 53)	0	
58. 00	Bonus payment (see instructions)	riig cost and targe	t amount (Time	JO IIII IIUS TI	116 33)	ő	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period end	ing 1996, upda	ted and comp	ounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, updat	ed by the mark	et basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		lines 54 x 60)	, or 1% or t	ne target		
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructi	ons)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decembe	r 31 of the co	st reporting	period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cost	reporting p	eriod (See	0	65. 00
	instructions)(title XVIII only)				•	_	
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line 64	plus line 65)(title XVIII	only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through De	cember 31 of t	he cost repo	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dece	mber 31 of the	cost report	ina period	0	68. 00
	(line 13 x line 20)				3 1		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU	•				0	69.00
	Skilled nursing facility/other nursing facil	ty/ICF/IID routin	e service cost				70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		/U ÷ line 2)				71.00
73. 00	Medically necessary private room cost application	abĺe to Program (I		35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•		sheet B Par	rt II column		74. 00 75. 00
	26, line 45)		(II om work	oot b, rai	, GOT GIIIIT		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			ine 78 minus	: line 70\		79. 00 80. 00
81. 00	Inpatient routine service costs for compa		m. tation (I	ine 70 minus	, , , , , , , , , , , , , , , , , , , ,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I	,					82. 00 83. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:						84.00
85. 00	Utilization review - physician compensation	(see instructions)					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		gn 85)				86.00
87. 00	Total observation bed days (see instructions))	2)			0	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	ne 2)				88. 00 89. 00
57.00	(36)	40 (1 0113)				١	, 57.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014		
		Component	CCN: 15T011	To 06/30/2015	Date/Time Pre	
		Ti +	le XIX	Subprovi der -	Cost	14 (111)
		11.0	IC XIX	IRF	0031	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	1					
90.00 Capital -related cost	539, 778	4, 146, 630	0. 13017	3 0	0	90. 00
91.00 Nursing School cost	0	4, 146, 630	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	4, 146, 630	0.00000	0 0	0	92. 00
93.00 All other Medical Education	0	4, 146, 630	0.00000	0 0	0	93. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 7:	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			8, 115, 050		30.00
31.00 03100 INTENSIVE CARE UNIT			3, 445, 960		31.00
10. 00 04000 SUBPROVI DER - 1 PF			0		40.00
I1. 00 04100 SUBPROVI DER - I RF			0		41.00
12. 00 04200 SUBPROVI DER			0		42.00
13. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 18021		2, 223, 172	
51. 00 05100 RECOVERY ROOM		0.00000		0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 43538	•		
57. 00 05700 CT SCAN		0. 04311			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 30697	•		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 41633	•	399, 409	
50. 00 06000 LABORATORY		0. 94264			
50. 01 06001 0NCOLOGY		0. 53304	•	6, 519	
50. 02 06002 RADI ATI ON ONCOLOGY		0.00000		0	60. 02
55. 00 O6500 RESPIRATORY THERAPY		0. 47018		753, 175	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 31158			
59. 00 06900 ELECTROCARDI OLOGY		0. 24713		513, 839	
99. 01 06901 CARDI AC REHAB		0. 59787		0	69.0
71. 00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.00000		0	71.00
12.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		742 720	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 24505	3, 034, 962	743, 739	73.00
OUTPATIENT SERVICE COST CENTERS OO OO OOOO CLINIC		1. 95686	0	0	90.00
		0. 17907			
11.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 17907		679, 633 0	91. 00 92. 00
22. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)		0.00000		0	92.00
OTHER REIMBURSABLE COST CENTERS		0.00000	0	0	j 92.01
25 OO O9500 AMBIII ANCE SERVI CES					95.00

30, 140, 143

30, 140, 143

95.00

201. 00 202. 00

7, 495, 130 200. 00

95. 00 09500 AMBULANCE SERVICES

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

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

200.00

201.00 202.00

	Financial Systems MARION GENERAL H ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150011	Peri od:	Worksheet D-3	
		Componen	t CCN: 15T011	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 7:	pared: 14 am
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	INDATI ENT. DOUTINE CEDVICE COCT CENTEDO		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		T	0		30.00
30.00	03100 NTENSI VE CARE UNIT			0		31.00
40. 00	04000 SUBPROVI DER - I PF			0		40.00
41. 00	04100 SUBPROVI DER – I RF			3, 415, 223		41.00
42. 00	04200 SUBPROVI DER			0, 110, 220		42. 00
43. 00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS		•			1
50. 00	05000 OPERATI NG ROOM		0. 1802	18 69, 650	12, 552	50.00
51. 00	05100 RECOVERY ROOM		0.00000	00	0	51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 43538		14, 514	•
57. 00	05700 CT SCAN		0. 0431		2, 661	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 3069		3, 069	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 41633		1, 243	
60.00	06000 LABORATORY		0. 94264		66, 046	
60. 01	06001 0NCOLOGY		0. 53304		472	
60. 02 65. 00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY		0. 00000 0. 47018		0 40, 090	
66. 00	06600 PHYSI CAL THERAPY		0. 47018		717, 794	
	06900 ELECTROCARDI OLOGY		0. 24713		9, 313	
69. 01	06901 CARDI AC REHAB		0. 5978		0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		Ö	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2450		93, 293	73.00
	OUTPATIENT SERVICE COST CENTERS					1
90. 00	09000 CLI NI C		1. 95686		0	90.00
91. 00	09100 EMERGENCY		0. 1790		6, 720	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6869		0	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)		0.00000	00 0	0	92. 01
25 00	OTHER REIMBURSABLE COST CENTERS					1 05 00
	09500 AMBULANCE SERVICES			2 002 400	047 747	95. 00
200. 00 201. 00		(Lino 61)		3, 093, 489	967, 767	200.00
201.UU	Less for citilic Laboratory services-Program only charges	(TITIE OI)	1	1 0		1201.00

	ON GENERAL HOSPITAL	CCN 150011		u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150011	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Pre 11/23/2015 7:	pared:
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	<u> </u>	Ratio of Cos		Inpati ent	
, , , , , , , , , , , , , , , , , , ,		To Charges		Program Costs	
		3	Charges	(col. 1 x col.	
			ŭ	2)	
		1.00	2. 00	3. 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
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					1
50. 00 05000 OPERATING ROOM		0. 18021	8 1, 918, 099	345, 676	50.00
51. 00 05100 RECOVERY ROOM		0. 00000	0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 43538	101, 261	44, 088	54.00
57. 00 05700 CT SCAN		0. 04311	2 329, 594	14, 209	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 30697	79 20, 983	6, 441	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 41633	214, 286	89, 214	59.00
60. 00 06000 LABORATORY		0. 94264	191, 741	180, 743	60.00
60. 01 06001 0NC0L0GY		0. 53304	17 2, 176	1, 160	60. 01
60. 02 06002 RADIATION ONCOLOGY		0. 00000	0 0	0	60. 02
65. 00 06500 RESPI RATORY THERAPY		0. 47018	36 265, 989	125, 064	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 31158	105, 701	32, 935	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 24713	187, 758	46, 401	69.00
69. 01 06901 CARDI AC REHAB		0. 59787	75 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 24505	547, 065	134, 062	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		1. 95686	06	0	90.00
91. 00 09100 EMERGENCY		0. 17907	628, 441	112, 537	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 68691	7 0	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 00000	00	0	92. 01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00

1, 132, 530 200. 00

4, 513, 094

4, 513, 094

95.00

201. 00 202. 00

95. 00 09500 AMBULANCE SERVICES

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

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

200.00

201. 00 202. 00

Health Financial Systems MARION GENERAL HOSPITA	ΔI	In lie	eu of Form CMS-:	2552-10
	vi der CCN: 150011	Peri od:	Worksheet D-3	
Com	oonent CCN: 15T011	From 07/01/2014 To 06/30/2015		pared:
	Title XIX	Subprovi der -	Cost	14 (1111
Cost Center Description	Ratio of Co To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		0	I	30.00
31. 00 03100 NTENSI VE CARE UNI T				31.00
40. 00 04000 SUBPROVI DER - 1 PF		0		40.00
41. 00 04100 SUBPROVI DER - RF		147, 111		41. 00
42. 00 04200 SUBPROVI DER		0		42. 00
43. 00 04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS	<u> </u>			
50. 00 05000 OPERATING ROOM	0. 1802	.18 0	0	50.00
51.00 05100 RECOVERY ROOM	0.0000			51. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 4353		92	54.00
57. 00 05700 CT SCAN	0. 0431			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 3069			
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 4163			
60. 00 06000 LABORATORY	0. 9426			
60. 01 06001 0NCOLOGY	0. 5330			
60. 02 06002 RADIATION ONCOLOGY	0.0000		0	60. 02
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 4701			
69. 00 06900 ELECTROCARDI OLOGY	0. 3115 0. 2471	·		1
69. 01 06901 CARDI AC REHAB	0. 5978			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.0000			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.0000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 2450		_	
OUTPATIENT SERVICE COST CENTERS		2, 121	.,	1
90. 00 09000 CLI NI C	1. 9568	866 0	0	90.00
91. 00 09100 EMERGENCY	0. 1790		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 6869	0 17	0	92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0.0000	000 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES				95. 00
200.00 Total (sum of lines 50-94 and 96-98)		113, 254		200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line	61)	0		201. 00
202.00 Net Charges (line 200 minus line 201)		113, 254		202. 00

TILE XVIII Sept 14 PS	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der		Peri od: From 07/01/2014 To 06/30/2015		pared:
MBR_A			Ti +I	o XVIII	Hospi tal		14 am
Design 1.00 1.00 1.01 2.00 1.00 1.01 2.00 1.00			11 (1			FF3	
1.00 Disc Amounts other than Outil or Payments 0			0			2. 00	
1.01 Bild amounts other than outlier psyments for discharges 3,064,362 1.01							
1.02 Side amounts other than out For payment for ord scharges 10,751,905 1.02 1.03 1.0		1			-		
1.02 DRG amount's other than outlier payments for discharges 10,751,505 1.02 1.03	1.01			3, 084, 30	12		1.01
1.03 BRC for Toderal specific operating purposes for Nodel 4 0 1.03 BRC for Colcharge Society of Detactor (See BRC) 1.04 BRC for Colcharge Society of Detactor (See BRC) 1.04 BRC for Colcharge Specific Operating pages for Nodel 4 BRC for Colcharge Specific Operating pages for Nodel 4 BRC for Colcharge Specific Operating Detactor (See Instructions) 29,836 2.00	1.02			10, 751, 50	15		1. 02
BRC For discharges occurring prior to October 1 (see Instructions) 1.04 DRC for Federal specific operating payment for Model 4 0 0 1.04 1.0							
Instructions	1. 03				0		1. 03
1.04 BRC for Tederial specific operating payment for World 4 0 1.04 BRC for Tederial specific operating on an attra October 1 (see 1.04							
BRCI for discharges occurring on or after October 1 (see	1.04				0		1. 04
2.00 Outlier payments for discharges (see instructions)							
2.01 Out increase instruction amount 0 2.01 Instructions 0 2.02 Out instructions 0 2.02 Out instructions 0 2.02 Out Instructions 0 0 2.02 Out Instructions 0 0 0 0 0 0 0 0 0							
Outlier payment for discharges for Model 4 BPCI (see 0 3.0		, , , , , , , , , , , , , , , , , , , ,		29, 83			
Instructions					-		
Bed days available of ivided by number of days in the cost Pepertring period (see Instructions)	2.02						2.02
report fing period (see instructions)	3.00	Managed Care Simulated Payments			0		3. 00
Indirect Medical Education Adjustment 5.00 5.	4.00			88. C	17		4. 00
FTE count for all opathic and esteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see instructions)							
most recent cost reporting period ending on or before 12/31/1996, (see instructions) 6.00 FTE count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.70(e) 7.00 MAR Section 422 reduction amount to the IME cap as 0.00 7.00	5 00			0.0	0		5.00
### Count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MM Section 422 reduction amount to the IME cap as \$ 0.00 7.00 7.00 7.00 7.00 7.00 7.00 7.	0.00			0.0			0.00
meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(c) 7. 00 MAA Section 422 reduction amount to the IME cap as							
programs in accordance with 42 CFR 413.79(c) Name Section 422 reduction amount to the IME cap as specified under 42 CFR 8412.105(f)(1)(iv)(8)(1) 7. 01 ALA Section 5503 reduction amount to the IME cap as specified under 42 CFR 8412.105(f)(1)(iv)(8)(2) If the cost report stradies July 1, 2011 then see instructions. 8. 00 Adjustment (increase or decrease) to the FIE count for all lopathic and osteopathic programs for affil lated programs in accordance with 42 CFR 413.75(b). 50069 (August 1, 2002) 8. 01 The amount of Increase if the hospital was awarded FIE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of Increase if the hospital was awarded FIE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions) 10. 00 FIE count for all lopathic and osteopathic programs in the current year from your records FIE count for residents in dental and podiatric programs. 10. 00 FIE count for residents in dental and podiatric programs. 11. 00 FIE count for residents in dental and podiatric programs. 12. 00 Current year all powable FIF (see instructions) 13. 00 FIE count for residents in initial years of the program 14. 00 FIE count for residents in initial years of the program 15. 00 Sum of lines 12 through 14 divided by 3. 16. 00 Adjustment for residents in initial years of the program 16. 00 On 15. 00 17. 00 Adjustment for residents in initial years of the program 17. 00 Current year resident to bed ratio (see instructions) 18. 00 On 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 20. 00 19. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 01 28. 01 EMB ENDER SE	6.00			0.0	00		6. 00
MM\ Section 422 reduction amount to the IME cap as specified under 42 CFR 5412 - DIS(ff)(1)(v)(0)(0)(1)(0)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		· ·					
Specified under 42 CFR \$412.105(ff)(1)(1)(1)(1)(1)(1) Color Specified under 42 CFR \$412.105(ff)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	7. 00	1, 9		0.0	0		7. 00
Specified under 42 CFR \$412.105(T)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		· ·					
cost report straddles July 1, 2011 then see instructions. 8.00 All pathic cand esteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) (2) (iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap 0.00 8.01 Stock studer section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap 0.00 8.02 Stots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.00 11.00 1	7. 01			0.0	0		7. 01
Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs in accordance with 42 CFR 413.75(b).							
al Lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) (2) (1v), 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 slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.00 Sum of Ilines 5 plus 6 minus Ilines (7 and 7.01) plus/minus ilines (8, 8, 01 and 8, 02) (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 11.00 FTE count for residents in dental and podiatric programs. 10.00 Total allowable FTE count for the prior year. 10.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of Ilines 12 through 14 divided by 3. 16.00 Adj ustment for residents in initial years of the program 0.00 11.00	8 00			0.0	0		8 00
### 413.79(c)(2)(1y), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). ### 80009 (August 1, 2002). ### 80009 (August 1, 2001). ### 80009 (August	0.00						0.00
S00.09 (August 1, 2002).							
Section The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.							
Storts under section 5503 of the ACA. If the cost report	8 N1			0.0	10		8 01
Straddles July 1, 2011, see instructions. 8.02	0.01			0.0			0.01
Slots From a closed teaching hospital under section 5506 of ACA (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus 0.00 11.00		straddles July 1, 2011, see instructions.					
Of ACA. (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus 0.00 1.	8. 02			0.0	00		8. 02
9.00 Sum of lines 5 plus 6 mlnus lines (7 and 7.01) plus/minus 0.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 10.00 11							
10.00 FTE count for residents in dental and podiatric programs in the current year from your records 11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00	9.00	·		0.0	0		9. 00
Current year from your records							
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 10.00 12.00 12.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 14.00 14.00 14.00 14.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 17.00 17.00 18.00 1	10. 00			0.0	00		10. 00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 17.00 18.00	11 00			0.0	10		11 00
13.00 Total allowable FTE count for the prior year. 0.00 14.00 15.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00				•			
year ended on or after September 30, 1997, otherwise enter zero. 15. 00 Sum of lines 12 through 14 divided by 3. 16. 00 Adjustment for residents in initial years of the program 0.00 17. 00 Adjustment for residents of initial years of the program 0.00 18. 00 Adjustment for residents of isplaced by program or hospital 0.00 19. 00 Current year resident to bed ratio (line 18 divided by 19.000000000000000000000000000000000000							
Zero.	14.00			0.0	0		14. 00
15.00 Sum of lines 12 through 14 divided by 3.							
16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjusment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0.000000 22.00 11 ME payment adjustment (see instructions) 0 22.01 11 ME payment adjustment for the Add-on for Section 422 of the MMA 22.01 23.00 Number of additional all opathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 1ME payments adjustment factor. (see instructions) 0.00000	15 00			0.0	0		15 00
17. 00 Adj usment for residents displaced by program or hospital 0.00 17. 00 18. 00 18. 00 19. 00 18. 00 19. 00				l .			
18.00 Adjusted rolling average FTE count 0.00 19.00	17. 00	Adjusment for residents displaced by program or hospital		0.0	0		17. 00
19.00 Current year resident to bed ratio (line 18 divided by line 4). 19.00 19.00 19.00 19.00 19.00 19.00 20.00 21.00 21.00 21.00 21.00 21.00 22.00 19.00 22.00 19.0	40.00						10.00
Line 4). Prior year resident to bed ratio (see instructions) 0.000000 20.00 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 25.00 25.00 IME payments adjustment factor. (see instructions) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 1000 2000		, ,					
20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 23.00 IME payment adjustment - Managed Care (see instructions) 24.00 IME payment adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(c). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 20.00 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.02 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.02 IME add-on adjustment amount - Managed Care (see instructions) 20.00 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.01 IME add-on adjustment amount - Managed Care (se	19.00			0.00000			19.00
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 1 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions)	20.00			0.00000	0		20. 00
22. 01 IME payment adjustment - Managed Care (see instructions) 10 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412. 105 (f)(1)(iv)(c). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment factor. (see instructions) 28. 01 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions)		i i i i i i i i i i i i i i i i i i i		1			
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 1 IME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions)				1			
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 23.00 24.00 25.00 26.00 27.00 28.00 28.01	22. 01		ion 122 of t		U		22.01
resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 1 IME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions)	23. 00		1011 422 01 1		0		23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions)							
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26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions)	25. 00			0.0	0		25. 00
27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 1 ME add-on adjustment amount - Managed Care (see instructions)	26 00			0 00000	00		26 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.00 28.01 instructions)							
instructions)	28. 00	IME add-on adjustment amount (see instructions)			0		28. 00
	28. 01				0		28. 01
27. 55 15 tal 1 mz paymont (3am 61 11 nos 22 ana 20)	20 00	· · · · · · · · · · · · · · · · · · ·			0		20 00
		Total Time paymont (Sam of Times 22 and 20)		<u> </u>	<u> </u>		

Deferre 171		Financial Systems ATION OF REIMBURSEMENT SETTLEMENT	MARION GENERAL	Provi der	F	Period: From 07/01/2014 To 06/30/2015	11/23/2015 7:	pared:
10-12 No. 10-12 No. 10-12 2-00				Ti tl		Hospi tal	PPS	
20 07 Total ME payment - Managed Care (sum of Hines 22.01 and			-	0			2. 00	
30.00 Percentage or SSI recipient partient days (see instructions) 23.39 27.10	29. 01	28. 01)	es 22.01 and	<u> </u>				29. 01
31.00 Percentage of Medical patient days (see instructions) 22.00 500 of in ins 30 and 31.00 33.00 34.00 500 of ins 30 and 31.00 33.00 34.00 35.00	30. 00	Percentage of SSI recipient patient days to M	Medicare Part		5. 58	3		30. 00
33.00 All Javable disproportionate share percentage (see 13.78 33.00 10 surporti towale share adjustment (see instructions) 460, 551 34.00 60 surporti towale share adjustment (see 0 1.00 1.01 2.00 1.03 33.00 10 surporti development (see 0 1.00 1.01 2.00 1.03 33.00 10 surporti organizate dare amount (see 0,046,380,143 7,647,648,689 33.00 10 surporti organizate dare amount (see 0,046,380,143 7,647,648,689 35.00 10 surporti organizate dare amount (see 0,00018796 0,00018796 0,00018796 1,178,346 1,178,346 1,178,346 1,178,346 1,178,346 1,178,346 35.00 10 surporti organizate dare amount (see 0,00018796 0,000		Percentage of Medicaid patient days (see inst	ructions)					31.00
Prior to October 1		Allowable disproportionate share percentage (see		1			33. 00
Incompensated Care Adjustment	34. 00	Disproportionate share adjustment (see instru	uctions)				On/After	34. 00
Incompensated Care Adjustment			0			1 01		
Instructions 1.0		Uncompensated Care Adjustment	0		1.00	1.01	2.00	
So of Factor 3 (see instructions) 0.000147542 35.01	35. 00				9, 046, 380, 143	3	7, 647, 644, 885	35. 00
Second S	35. 01				0.000135796		0. 000147542	35. 01
Pro rata share of the hospital uncoepensated care symmet amount (see instructions) 3,0,000 343,941 3,03 36,00 36,0		Hospital uncompensated care payment (If line 34 is zero, enter zero on this line)			1, 228, 462	2		1
10 10 10 10 10 10 10 10	35. 03	Pro rata share of the hospital uncompensated			309, 640	O	843, 941	35. 03
Additional payment for high percentage of ESRO beneficiary discharges (lines 40 through 4c) 40.00 Total folding discharges for MS-DROS 652, 682, 683, 684 and 685 (see instructions) 41.00 4	36. 00	Total uncompensated care (sum of columns 1			1, 153, 581			36. 00
Part excluding discharges for MS-DROS 652, 682, 683, 684 and 685 (see instructions)	10.00	Additional payment for high percentage of ESF	D beneficiary d	lischarges (Li	nes 40 through	46)		40.00
11.00 Total ESRD Wedicare discharges excluding	40.00	Part I excluding discharges for MS-DRGs 652,)		40.00
1.01 Total ESRD Medicare covered and paid disparages excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 0.00 42.00 0.00 42.00 0.00 42.00 0.00 42.00 0.00 42.00 0.00 42.00 0.00 42.00 0.00 42.00 0.00 42.00 0.00 43.00 0.00 43.00 0.00 43.00 0.00 43.00 0.00 43.00 0.00 43.00 0.00 43.00 0.00 44.00 43.00 0.00 44.00 44.00 44.00 45.00	41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see				0		41. 00
42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 42.00 43.00 70 70 70 70 70 70 70	41. 01	Total ESRD Medicare covered and paid			(0		41. 01
43.00 Total Medicare ESRD inpatient days excluding MS-DROS 652 682 683 684 an 685 (see instructions)	42. 00	Divide line 41 by line 40 (if less than 10%,			0.00			42. 00
Instructions	43. 00	Total Medicare ESRD inpatient days excluding)		43. 00
days	44. 00	instructions) Ratio of average length of stay to one week			0. 000000	O		44. 00
46.00 Total additional payment (line 45 times line 44 times line 41.01) 41 times line 41.01) 41 times line 41.01) 42 times line 41.01) 43.00 44 times line 41.01) 47.00 50 times line 41.01) 47.00 50 times line 41.01) 47.00 48.0	45. 00	days) Average weekly cost for dialysis treatments			0.00	0.00		45. 00
47.00 Subtotal (see instructions) 48.00 Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions) 49.00 Total payment for inpatient operating costs (see instructions) 50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) 52.00 Direct graduate medical education payment (from Wkst. E.4, line 49 see instructions) 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. I, Iine 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 10.011 10.583,640 11.05	46. 00	Total additional payment (line 45 times line			()		46. 00
by SCH and MDH, small rural hospitals only. (see Instructions) 49. 00 Total payment for inpatient operating costs (see Instructions) 50. 00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 51. 00 Exception payment for inpatient program capital (wst. L, Pt. III, see instructions) 52. 00 Direct graduate medical education payment (from Wkst. E.4, IIIn 49 see instructions) 53. 00 Nursing and Allied Health Managed Care payment 54. 00 Special add-on payments for new technologies 55. 00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. I, Iine 69) 56. 00 Cost of physicians' services in a teaching hospital (see intructions) 57. 00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58. 00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59. 00 Total (sum of amounts on lines 49 through 58). 60. 00 Primary payer payments 10, 011 10, 583, 640 61. 00		Subtotal (see instructions)						47. 00 48. 00
(see instructions) 50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) 52.00 Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 10,011 16,593,651 59.00 Total amount payable for program beneficiaries (line 59 minus line 60)		by SCH and MDH, small rural hospitals only. (see instructions)						
Wkst. L, Pt. I and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments Primary payer payments Primary payable for program beneficiaries (line 59 minus line 60)		(see instructions)						
capital (Wkst. L, Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions). Nursing and Allied Health Managed Care payment 53.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60)		Wkst. L, Pt. I and Pt. II, as applicable)						
(from Wkst. E-4, line 49 see instructions). 53.00 Nursing and Allied Health Managed Care payment 54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)		capital (Wkst. L, Pt. III, see instructions)						52. 00
54.00 Special add-on payments for new technologies 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) 56.00 Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60)	53. 00	(from Wkst. E-4, line 49 see instructions).)		53. 00
III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intructions) 57.00 Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)		Special add-on payments for new technologies			3, 175	5		54.00
hospital (see intructions) Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 60.00 Total amount payable for program beneficiaries (line 59 minus line 60)		III, col. 1, line 69)						
through 35). 58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 10,011 60.00 61.00 Total amount payable for program beneficiaries (line 59 minus line 60)		hospital (see intructions) Routine service other pass through costs						57. 00
59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 59.00 10,011 16,593,651 60.00 61.00	58. 00	through 35). Ancillary service other pass through costs						58. 00
60.00 Primary payer payments 10,011 16,583,640 61.00 Primary payer payments 10,011 16,583,640 61.00	59. 00	Total (sum of amounts on lines 49 through			16, 593, 651			59. 00
beneficiaries (line 59 minus line 60)		Primary payer payments						60.00
		beneficiaries (line 59 minus line 60)						62. 00

_ !	nearth Financial Systems	WARTON GENERAL HOSFITAL	III LIE	u 01 101111 0113-2332-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	Peri od:	Worksheet E
			From 07/01/2014	Part A
			To 06/30/2015	Date/Time Prepared:
				11/23/2015 7:14 am

				10	06/30/2015	11/23/2015 7:	
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
		•		October 1	1 01	October 1	
63. 00	Coinsurance billed to program beneficiaries	0		1. 00 10, 545	1. 01	2. 00	63. 00
64. 00	Allowable bad debts (see instructions)			136, 420			64. 00
65. 00	Adjusted reimbursable bad debts (see			88, 673			65. 00
	instructions)						
66. 00	Allowable bad debts for dual eligible			29, 139			66. 00
67. 00	beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines			14, 822, 276			67. 00
07.00	62 and 63)			14, 022, 270			07.00
68. 00	Credits received from manufacturers for			0			68. 00
	replaced devices for applicable to MS-DRGs						
(0.00	(see instructions)						40.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see			٥			69. 00
	instructions)						
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
70 F0	(SPECIFY)						70 50
70. 50 70. 89	RURAL DEMONSTRATION PROJECT Pioneer ACO demonstration payment adjustment			0			70. 50 70. 89
70.07	amount (see instructions)						70.07
70. 90	HSP bonus payment HVBP adjustment amount			0			70. 90
70.01	(see instructions)						70.01
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			٥			70. 91
70. 92	Bundled Model 1 discount amount (see			О			70. 92
	instructions)						
70. 93	HVBP payment adjustment amount (see			16, 822			70. 93
70. 94	instructions) HRR adjustment amount (see instructions)			o			70. 94
70. 94	Recovery of accelerated depreciation			0			70. 94
70. 96	Low volume adjustment for federal fiscal		0	Ö			70. 96
	year (yyyy) (Enter in column O the						
	corresponding federal year for the period						
70. 97	prior to 10/1) Low volume adjustment for federal fiscal		0	0			70. 97
	year (yyyy) (Enter in column 0 the		Ü				70.77
	corresponding federal year for the period						
70.00	ending on or after 10/1)						70.00
70. 98 70. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)			0			70. 98 70. 99
71. 00	Amount due provider (line 67 minus lines 68			14, 839, 098			71.00
	plus/minus lines 69 & 70)						
71. 01	Sequestration adjustment (see instructions)			296, 782			71. 01
72. 00 73. 00	Interim payments Tentative settlement (for contractor use			14, 995, 537 0			72. 00 73. 00
73.00	only)			U			73.00
74. 00	Balance due provider (Program) (line 71			-453, 221			74. 00
75 00	minus lines 71.01, 72, and 73)			4 440 005			75.00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,			1, 143, 305			75. 00
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 throu	igh 96)					
90. 00	Operating outlier amount from Wkst. E, Pt.			0			90. 00
91. 00	A, line 2 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2			o			91. 00
92. 00	Operating outlier reconciliation adjustment			o			92. 00
	amount (see instructions)						
93. 00	Capital outlier reconciliation adjustment			0			93. 00
94. 00	amount (see instructions) The rate used to calculate the time value of			0. 00			94. 00
74. UU	money (see instructions)			0.00			74.00
95. 00	Time value of money for operating expenses			О			95. 00
o	(see instructions)						
96. 00	Time value of money for capital related expenses (see instructions)			0			96. 00
	Texpenses (See ThatfuellOlls)		l	ı	ı		1

Health Financial Systems	MARION GENERAL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der		Peri od: From 07/01/2014 To 06/30/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
			Prior to 10/	1	On/After 10/1	
			1. 00	1. 01	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	0	101. 00
102.00 HVBP adjustment amount for HSP bonus payment	(see instructions)			0	0	102. 00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)			0.000	00	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 | Peri od: | Worksheet E | From 07/01/2014 | Part A Exhi bit 4 | To 06/30/2015 | Date/Ti me Prepared: | 11/23/2015 7: 14 am Provider CCN: 150011

						0 00/30/2013	11/23/2015 7:	14 am
		W/C E Dowt A	Amounto (from		e XVIII	Hospi tal	PPS Total (Col 2	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	C	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	3, 084, 362	0	3, 084, 362	0	3, 084, 362	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	10, 751, 505	0	C	10, 751, 505	10, 751, 505	1. 02
1. 03	occurring on or after October 1 DRG for Federal specific	1. 03	O	0	C	О	0	1. 03
	operating payment for Model 4 BPCI occurring prior to October 1							
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	C	0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	29, 836	0	5, 125	24, 711	29, 836	2. 00
2. 01	Outlier payments for	2. 02	О	0	C	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	C	0	0	3. 00
4. 00	reconciliation Managed care simulated	3. 00	0	0	C	0	0	4. 00
	payments Indirect Medical Education Adju						-	
5. 00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	O	0	C	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	О	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	C	О	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	О	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	О	0	9. 01
	Di sproporti onate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1328	0. 1328	0. 1328	0. 1328		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	459, 351	0	102, 401	356, 950	459, 351	11. 00
11. 01	Uncompensated care payments	36. 00	1, 153, 581	0	309, 640	631, 221	940, 861	11. 01
40.05	Additional payment for high per		RD beneficiary					40.05
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	С		0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	15, 478, 635 15, 057, 094	0	3, 501, 528 C	11, 977, 107 0	15, 478, 635 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	15, 478, 635	0	3, 501, 528	11, 977, 107	15, 478, 635	15. 00
16. 00	instructions) Payment for inpatient program	50. 00	1, 111, 841	0	247, 742	864, 099	1, 111, 841	16. 00
17. 00	Special add-on payments for	54. 00	3, 175	0	1, 588	1, 588	3, 176	17. 00
17. 01	new technologies Net organ aquisition cost	55. 00	0	0	С	0	0	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	C	0	0	18. 00

LOW VC	DELUME CALCULATION EXHIBIT 4					From 07/01/2014 To 06/30/2015	Part A Exhibi Date/Time Pre 11/23/2015 7:	pared:
		W/C F D I A	1 (6		e XVIII	Hospi tal	PPS	
		· ·	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
10.00	CURTOTAL	0	1.00	2.00	3.00	4. 00	5. 00	10.00
19.00	SUBTOTAL	W/C 1 1:	(1)	0	3, 750, 85	8 12, 842, 794	16, 593, 652	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier		1, 105, 756	0	246, 53	859, 217	1, 105, 755	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	6, 085	0	1, 20	4, 882	6, 086	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see	10. 00	0. 0000	0. 0000	0. 000	0. 0000		24. 00
25. 00	instructions) Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 111, 841	0	247, 74	2 864, 099	1, 111, 841	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000	0. 000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	0	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HU3P1 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5		FI To		Date/Time Pre 11/23/2015 7:	pared:
			Title	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	3, 084, 362	3, 084, 362	0.00	3, 084, 362	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 02	10, 751, 505		10, 751, 505	10, 751, 505	1. 02
1. 03	discharges occurring on or after October 1 DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
1.04	for Model 4 BPCI occurring prior to October	4.04					4.04
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00	29, 836	5, 125	24, 711	29, 836	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0		
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0 0	0 0		3. 00 4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	o	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	9. 01
	Disproportionate Share Adjustment		1				
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1328	0. 1328	0. 1328		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	459, 351	102, 401	356, 950	459, 351	11. 00
11. 01	Uncompensated care payments	36.00	1, 153, 581	309, 640	631, 221	940, 861	11. 01
	Additional payment for high percentage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12. 00
13.00	Subtotal (see instructions)	47.00	15, 478, 635	3, 501, 528	11, 977, 107	15, 478, 635	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	15, 057, 094	3, 300, 687	11, 756, 407	15, 057, 094	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	15, 478, 635	3, 501, 528	11, 977, 107	15, 478, 635	15. 00
16.00	Payment for inpatient program capital	50.00	1, 111, 841	247, 742	864, 099		16. 00 17. 00
17.00	Special add-on payments for new technologies	54.00	3, 175	1, 587	1, 588		
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for	55. 00 68. 00	0	0	0	0	17. 01 17. 02
18. 00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
	amount (see instructions) SUBTOTAL			3, 750, 857	12, 842, 794		
						'	

				To 06/30/2015		pared:
		Ti tl	e 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	1, 105, 756	246, 53	8 859, 218	1, 105, 756	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	6, 085	1, 20	4, 881	6, 085	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	0.0000	0. 000	0. 0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.000	0. 0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0		0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	1, 111, 841	247, 74	2 864, 099	1, 111, 841	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1. 00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		o	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	16, 822	-8, 25	25, 074	16, 822	30.00
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	0		0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1. 00	2. 00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	02.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	Peri od: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/23/2015 7:14 am

			To 06/30/2015	Date/Time Pre 11/23/2015 7:	
		Title XVIII	Hospi tal	PPS	
	DART R. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			8, 661	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructi	ons)		20, 061, 817	2.00
3.00	PPS payments			16, 830, 939	•
4.00	Outlier payment (see instructions)			115, 678	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	•
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	ı
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	•
10. 00	Organ acquisitions	,		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 661	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges			24 402	12. 00
13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		20, 003	•
14. 00	Total reasonable charges (sum of lines 12 and 13)	0 07)		26, 603	
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa				15. 00
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			26, 603	•
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	17, 942	1
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00					21. 00
22. 00	Interns and residents (see instructions)	,		0	ı
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			16, 946, 617	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25. 00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions		3, 537, 165	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			13, 418, 113	1
	instructions)		·		
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 13, 418, 113	
31. 00	Primary payer payments			13, 418, 113	1
32. 00	Subtotal (line 30 minus line 31)			13, 416, 198	ı
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00	Allowable bad debts (see instructions)			898, 563	1
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		584, 066 661, 278	1
37. 00	Subtotal (see instructions)	Cti ons)		14, 000, 264	1
	MSP-LCC reconciliation amount from PS&R			0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 14, 000, 264	39. 99 40. 00
40. 00 40. 01	Sequestration adjustment (see instructions)			280, 005	1
41. 00					1
42.00				13, 537, 339 0	1
43.00	, , ,			182, 920	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	•
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	•
94.00	Total (sum of lines 91 and 93)		l	0	94. 00

Health Financial Systems MARANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150011

Interfim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.						11/23/2015 7:	14 am
1.00			Ti 1	le XVIII	Hospi tal	PPS	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpati	ent Part A	Pai	rt B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Inter-im payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero tame the cost reporting period. If none, write "NoNE" or enter a zero the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 3.01				2.00		4.00	
Inter-im payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero tame the cost reporting period. If none, write "NoNE" or enter a zero the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 3.01	1.00	Total interim payments paid to provider		14, 895, 3	39	13, 143, 309	1. 00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero tist separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00						2. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		submitted or to be submitted to the contractor for					
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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)		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)		amount based on subsequent revision of the interim rate					
Program to Provider ADJUSTMENTS TO PROVIDER 06/30/2015 100,198 06/30/2015 394,030 3.0							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 3.06 3.06 3.06 3.06 3.06 3.07							
3.03 3.04 3.05 3.05 3.06 3.07 3.07 3.08 3.09 3.09 3.00 3.00 3.00 3.00 3.00 3.00		ADJUSTMENTS TO PROVIDER	06/30/2015	100, 1	98 06/30/2015		3. 01
3.04 0 0 0 3.5 3.05						1	3. 02
3.50 Provider to Program						1	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0							3. 04
3.50 ADJUSTMENTS TO PROGRAM	3. 05				0	0	3. 05
3.51 0							
3.52 3.53 3.54 3.59 3.50		ADJUSTMENTS TO PROGRAM			-	1	3. 50
3.53 3.54 0 0 3.5 3.54 3.54 3.54 3.54 3.54 3.59 3.50-3.98 3.50-3.99 3.50-3					-	1	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.3.50-3.98) 100,198 394,030 3.9 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 14,995,537 13,537,339 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.00 0 0 5.00 0 0 5.00 0 0 0 0 0 0 0 0 0							3. 52
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 394,030 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 14,995,537 13,537,339 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 14,995,537 13,537,339 4.00 14,995,537 13,537,339 13,53					-	1	3. 53
3. 50-3.98 Total interim payments (sum of lines 1, 2, and 3.99)					-		3. 54
14, 995, 537 13, 537, 339 14, 995, 537 13, 537, 339 15, 537, 339 15, 537, 339 15, 537, 339 15, 537, 339 15, 537, 339 15, 537, 339 15, 537, 339 16, 537, 339 17, 537, 339 17, 537, 339 17, 537, 339 18,	3. 99	· ·		100, 1	98	394, 030	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		1 2 2 2 2 2 2					
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			14, 995, 5	3 /	13, 537, 339	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	E 00	List congretaly each tentative cottlement neumant after	I				E 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER		Program to Provider					
5.02 0	5 01				n	0	5. 01
5.03 Provider to Program S.50 TENTATIVE TO PROGRAM O O S.50 5.51 O O O S.50 5.52 O O O S.50 5.52 S.50 - S. 98 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROGRAM O Total Medicare program liability (see instructions) 14,542,316 13,720,259 7.00 7.00 Total Medicare program liability (see instructions) O T.00 2.00 7.00 Total Medicare program liability (see instructions) O T.00 2.00 8.00 T.00 T.00 T.00 T.00 T.00 T.00 T.00 8.01 T.02 T.03 T.03 T.03 T.03 T.03 8.02 T.03 T.03		TEMMINE TO TROVIDER					5. 02
Provider to Program							5. 03
TENTATI VE TO PROGRAM 0	0.00	Provider to Program				J	0.00
5.51 0	5. 50				0	0	5. 50
5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 51				0	o	5. 51
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 182, 920 6. 00 6. 02 SETTLEMENT TO PROGRAM 453, 221 0 0 6. 00 7. 00 Total Medicare program liability (see instructions) 14, 542, 316 13, 720, 259 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							5. 52
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines				1	5. 99
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		· ·					
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 182,920 6.0 453,221 0 6.0 13,720,259 7.0 Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	6.00				1		6. 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		,					
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 453, 221 14, 542, 316 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01				0	182, 920	6. 01
Contractor Number NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.02	SETTLEMENT TO PROGRAM		453, 2	21	ol	6. 02
Contractor Number NPR Date (Mo/Day/Yr) 0 1.00 2.00	7. 00	Total Medicare program liability (see instructions)		14, 542, 3	16	13, 720, 259	7. 00
0 1.00 2.00					Contractor	NPR Date	
					Number	(Mo/Day/Yr)	
8.00 Name of Contractor 8.00				0	1. 00	2.00	
	8.00	Name of Contractor					8. 00

Health Financial Systems MARANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Total interin payments paid to provider 1.00 Total interin payments paid to provider 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 3.00 4.00 1.00 3.00 4.00 1.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00			Ti tl	e XVIII	Subprovi der - I RF	PPS	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A	Par	rt B	
1.00 Total interim payments paid to provider 2.00 Total interim payments payable on individual bilis, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 Separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date or each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.00 3.01 3.02 3.03 3.03 3.04 3.05 3.			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1.00				
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			0		0	2.00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER O	3 00						3 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	0.00						0.00
Program to Provider							
ADJUSTMENTS TO PROVIDER		payment. If none, write "NONE" or enter a zero. (1)					
3.02 3.02 3.03 3.04 3.05 3.03 3.04 3.05 3.03 3.04 3.05							
3.03 0		ADJUSTMENTS TO PROVIDER		_			
3. 04 0 0 0 3. 04 3. 05 5. 05							
3.05							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50							
3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.50-3.98 0 0 0 3.59 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.104,768 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)	3.05	Provider to Program		U		0	3.05
3.51 3.52 3.53 3.53 3.54 3.52 3.53 3.54 3.59 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 4.104,768 0 0 3.53 3.54 3.50-3.98 4.104,768 0 0 0 3.54 3.59 3.50-3.98 4.104,768 0 0 0 3.59 3.50-3.98 4.104,768 0 0 0 3.59 4.104,768 0 0 0 3.59 4.104,768 0 0 0 0 0 0 0 0 0	3 50			0		0	3 50
3.52 3.53 3.54 3.99 3.50-3.98		ADSOSTMENTS TO TROOKAWI					
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 4.00 0 4.00 0 0 0 0 0 0 0 0 0							
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98) 4,104,768 0 3.99 4,104,768 0 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4,104,768 0 4.00				0		0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 4, 104, 768	3.54			0		0	3. 54
A. 00	3. 99			0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4. 00			4, 104, 768		0	4. 00
TO BE COMPLETED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER		write "NONE" or enter a zero. (1)					
S. 02 S. 03 Description S. 02 S. 03 S. 02 S. 03 Description S. 50							
Description		TENTATI VE TO PROVI DER					
Provider to Program						_	
TENTATI VE TO PROGRAM 0	5.03	Dravi dan ta Draggam		0		0	5.03
5.51 0	5 50			0		0	5 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0		TENTATI VE TO TROCKAW					
5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00	` ,					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 18,229 4,086,539 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	,			_		_	,
7.00 Total Medicare program liability (see instructions)				-			
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				•		-	
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total medicale program frability (see Histructions)		4, 000, 339			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			()			
	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems MARION GENERAL H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10		
From 07/01/2014 Pa To 06/30/2015 Da							
		Title XVIII	Hospi tal	PPS			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	4, 998	1. 00		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		8, 422	1		
3.00	.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 2,1						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		18, 061	4. 00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			364, 645, 861	5. 00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		53, 575, 785	6. 00		
7. 00	CAH only - The reasonable cost incurred for the purchase of ce line 168	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00		
8.00	Calculation of the HIT incentive payment (see instructions)			1, 429, 217	8. 00		
9.00	Sequestration adjustment amount (see instructions)			28, 584	9.00		
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1, 400, 633	10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,					
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 047, 642	30. 00		
	Other Adjustment (specify)			0	31.00		
32 00	00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 352 901 33						

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

352, 991 32. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150011		Worksheet E-3
	Component CCN: 15T011	From 07/01/2014 To 06/30/2015	
	Title XVIII	Subprovi der -	PPS

	IRF		
		1.00	
1 00	PART III - MEDICARE PART A SERVICES - IRF PPS	4 022 275	1 00
1. 00 2. 00	Net Federal PPS Payment (see instructions)	4, 032, 275 0. 0186	1. 00 2. 00
	Medicare SSI ratio (IRF PPS only) (see instructions)	1	
3. 00 4. 00	Inpatient Rehabilitation LIP Payments (see instructions)	87, 500 102, 701	3. 00 4. 00
5.00	Outlier Payments Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5.00
5.00	to November 15, 2004 (see instructions)	0.00	3.00
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	0.00	5. 01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		l
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	0.00	8. 00
9. 00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	8. 876712	10.00
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)	4, 222, 476	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)	4, 222, 476	17. 00
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	4, 222, 476	19. 00
20. 00	Deducti bl es	43, 220	
21. 00	Subtotal (line 19 minus line 20)		
22. 00	Coi nsurance	9, 318	
23. 00	Subtotal (line 21 minus line 22)	4, 169, 938	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	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)	4, 169, 938	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	0	29. 00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 99	Recovery of Accelerated Depreciation	0	31. 99
32.00	Total amount payable to the provider (see instructions)	4, 169, 938	
32. 01	Sequestration adjustment (see instructions)	83, 399	32. 01
33.00	Interim payments	4, 104, 768	
34.00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-18, 229	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	167, 920	36. 00
	TO BE COMPLETED BY CONTRACTOR		l
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	102, 701	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

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	Period: Worksheet E-3 From 07/01/2014 Part VII

To 06/30/2015 Date/Time Prepared: 11/23/2015 7:14 am

				11/23/2015 /:	14 am_
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		3, 103, 385		1.00
2.00	Medical and other services		-,,	0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		3, 103, 385	0	4. 00
5. 00	Inpatient primary payer payments		3, 103, 303	O	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		2 102 205	0	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		3, 103, 385	U	7.00
0.00	Reasonable Charges		2 240 407		0.00
8.00	Routine service charges		2, 240, 197	^	8. 00
9.00	Ancillary service charges		4, 513, 094	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	_	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		6, 753, 291	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for ser	rvices on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for pay		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CF	FR §413. 13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		6, 753, 291	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only it	fline 16 exceeds	3, 649, 906	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only it	fline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		3, 103, 385	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	oleted for PPS provide	rs.		
22. 00	Other than outlier payments	•	0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		O		24. 00
25. 00	Capital exception payments (see instructions)		o		25. 00
26. 00	Routine and Ancillary service other pass through costs		o	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		ol	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		ol	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		3, 103, 385	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		.,,		
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 103, 385	0	31.00
32. 00	Deducti bl es		0	0	32.00
33. 00	Coinsurance		0	0	33.00
34. 00	Allowable bad debts (see instructions)			0	34.00
35. 00				O	35. 00
36. 00			3, 103, 385	0	36.00
37. 00			3, 103, 303	0	37.00
38. 00			3, 103, 385	0	38.00
39. 00	· · · · · · · · · · · · · · · · · · ·		3, 103, 363	U	39.00
			2 102 205	0	40.00
40.00	, , , , , , , , , , , , , , , , , , , ,		3, 103, 385		
41. 00			3, 595, 376	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	STATE ONE DOLL 45 0	-491, 991	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance v	WITH CMS PUB 15-2,	0	0	43. 00
	chapter 1, §115.2		ı I		I

Health Financial Systems	MARION GENERAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150011	Peri od: From 07/01/2014	Worksheet E-3
	Component	CCN: 15T011		Date/Time Prepared: 11/23/2015 7:14 am
	Ti t	le XIX	Subprovi der -	Cost

		litle XIX	Subprovi der -	Cost	
			I RF	Outpati ant	
			I npati ent 1.00	Outpati ent 2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES EOD TITLES V OD VIV		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CES FOR TITLES V OR ATA	SERVICES		1
1.00	Inpatient hospital/SNF/NF services		183, 194		1.00
2. 00	Medical and other services		103, 174	0	
3.00	Organ acquisition (certified transplant centers only)			U	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		183, 194	0	1
5.00	Inpatient primary payer payments		103, 174	O	5. 00
6. 00	Outpatient primary payer payments		ď	0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		183, 194	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		103, 174		7.00
	Reasonable Charges				1
8.00	Routine service charges		148, 711		8.00
9. 00	Ancillary service charges		113, 254	0	
10.00	Organ acquisition charges, net of revenue		0	Ü	10.00
11. 00	Incentive from target amount computation		o		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		261, 965	0	
	CUSTOMARY CHARGES		2017 700		1 .2. 00
13. 00	Amount actually collected from patients liable for payment for s	services on a charge	O	0	13. 00
	basis			_	
14.00	Amounts that would have been realized from patients liable for p	payment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 42	3			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	. ,	0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		261, 965	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	78, 771	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instruc		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		183, 194	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	impleted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00 28. 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		183, 194	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		103, 194	0	29.00
30. 00	Excess of reasonable cost (from line 18)		O	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		183, 194	0	1
32. 00	Deductibles		103, 174	0	
33. 00	Coinsurance		o o	0	
34. 00	Allowable bad debts (see instructions)			0	1
35. 00	Utilization review		o	ŭ	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	183, 194	0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		o	0	
38. 00	Subtotal (line 36 ± line 37)		183, 194	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		o		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		183, 194	0	40.00
41.00	Interim payments		148, 569	0	
42.00	1 3		34, 625	0	1
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	o	0	43. 00
	chapter 1, §115.2				

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

Provider CCN: 150011 | Period: From 07/01/201-

Period: Worksheet G From 07/01/2014 To 06/30/2015 Date/Time Prepared: 11/23/2015 7: 14 am

				. 0 00, 00, 2010	11/23/2015 7:	14 am
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	I	1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	20.050.400			0	1 00
1. 00 2. 00	Cash on hand in banks	28, 858, 498			0	
3. 00	Temporary investments Notes receivable	2, 450, 350			0	
4. 00	Accounts receivable	45, 563, 515	1		0	
5. 00	Other recei vable	8, 186, 805			0	
6. 00	Allowances for uncollectible notes and accounts receivable	-28, 088, 425			0	
7. 00	Inventory	1, 716, 593		0	0	
8. 00	Prepaid expenses	1, 969, 468			0	
9. 00	Other current assets	717, 611		0	0	
10. 00	Due from other funds	, , , , , ,		o o	0	
11. 00	Total current assets (sum of lines 1-10)	61, 374, 415			0	
	FIXED ASSETS	217 21 17 112		-		
12.00	Land	4, 422, 248	3 (0	0	12. 00
13. 00	Land improvements	3, 341, 756	1	0	0	
14.00	Accumulated depreciation	-1, 945, 208	1	0	0	14. 00
15.00	Bui I di ngs	108, 209, 879		0	0	15. 00
16.00	Accumulated depreciation	-59, 249, 996		0	0	16.00
17.00	Leasehold improvements	871, 326		0	0	17. 00
18.00	Accumulated depreciation	-704, 239		0	0	18. 00
19. 00	Fi xed equipment	1, 005, 608	3	0	0	19. 00
20.00	Accumulated depreciation	-845, 381		0	0	20. 00
21. 00	Automobiles and trucks	1, 102, 002	2	0	0	21. 00
22. 00	Accumulated depreciation	-823, 171		0	0	22. 00
23. 00	Major movable equipment	76, 756, 278	3	0	0	23. 00
24.00	Accumul ated depreciation	-59, 484, 160) (0	0	24. 00
25.00	Mi nor equi pment depreciable	0)	0	0	
26. 00	Accumulated depreciation	0)	0	0	
27. 00	HIT designated Assets	0)	0	0	
28. 00	Accumulated depreciation	0)	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	4, 957, 546	1	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	77, 614, 488	3 (0	0	30.00
	OTHER ASSETS	105 700 040		-1		
31.00	Investments	185, 780, 343	10, 155		0	
32.00	Deposits on Leases			0	0	
33. 00	Due from owners/officers	0 107 051		0	0	1
34. 00	Other assets	9, 127, 251	•	0	0	
35. 00	Total other assets (sum of lines 31-34)	194, 907, 594			0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	333, 896, 497	10, 15	5 0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	5, 344, 784		0	0	37. 00
38. 00	Salaries, wages, and fees payable	10, 137, 126	1		0	
39. 00	Payroll taxes payable	10, 137, 120	1		0	
40. 00	Notes and Loans payable (short term)				0	
41. 00	Deferred income				0	
42. 00	Accel erated payments			0	0	42. 00
43. 00	Due to other funds			0	0	1
44. 00	Other current liabilities	3, 324, 278			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	18, 806, 188	1	o o		
.0.00	LONG TERM LIABILITIES	10/000/100		<u>, </u>		10.00
46. 00	Mortgage payable	0) (0	0	46. 00
47. 00	Notes payable			0	0	
48. 00	Unsecured Loans			0	0	
49. 00	Other long term liabilities	80, 153, 072		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49	80, 153, 072		0	0	1
51. 00	Total liabilites (sum of lines 45 and 50)	98, 959, 260		0	0	
	CAPI TAL ACCOUNTS		•			
52.00	General fund balance	234, 937, 237	1			52. 00
53.00	Specific purpose fund		10, 155	5		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	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant		1		0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	234, 937, 237			0	
60.00	Total liabilities and fund balances (sum of lines 51 and	333, 896, 497	10, 155	0	0	60.00
	[59]	l	I			

Provider CCN: 150011

					То	06/30/2015	Date/Time Prep 11/23/2015 7:	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		234, 742, 572			10, 155		1. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		194, 665			10 155		2.00
4. 00	Additions (credit adjustments) (specify)		234, 937, 237		0	10, 155	0	3. 00 4. 00
5.00	Additions (credit adjustments) (specify)				0			5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00		0			0		0	8. 00
9. 00 10. 00	Total additions (sum of line 4-9)	0	0		O	0	0	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		234, 937, 237			10, 155		10.00
12. 00	Deductions (debit adjustments) (specify)	0	234, 737, 237		0	10, 133	o	
13. 00	, (, (, (, (, (, (o			0		Ö	13. 00
14.00		0			0		0	14. 00
15. 00		0			0		0	15. 00
16. 00 17. 00		0			0		0	16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	١	0		U	0		18.00
19. 00	Fund balance at end of period per balance		234, 937, 237			10, 155		19. 00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	U	0		0			3. 00 4. 00
5.00	Additions (credit adjustments) (specify)		0					5. 00
6. 00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		O		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13.00			0					13.00
14. 00			0					14. 00
15. 00			0					15.00
16. 00 17. 00			0					16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)		J		0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)	1						

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150011

			To 06/30/2015	Date/Time Pre 11/23/2015 7:	
	Cost Center Description	I npati ent	Outpati ent	Total	
	'	1.00	2. 00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	19, 032, 0)96	19, 032, 096	1. 00
2.00	SUBPROVI DER - I PF		0	0	2. 00
3.00	SUBPROVI DER - I RF	3, 641, 0)22	3, 641, 022	3. 00
4.00	SUBPROVI DER		0	0	4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSI NG FACILITY				8. 00
9.00	OTHER LONG TERM CARE			00 (70 440	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	22, 673,	118	22, 673, 118	10. 00
11 00	Intensive Care Type Inpatient Hospital Services	7.541	77	7 544 /7/	11 00
11.00	INTENSIVE CARE UNIT	7, 541, 6	0/6	7, 541, 676	11.00
12. 00 13. 00	BURN INTENSIVE CARE UNIT				12. 00 13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes 7, 541, 6	576	7, 541, 676	
10.00	11-15)	7,541,0	,,,,	7,541,676	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	30, 214, 3	794	30, 214, 794	17. 00
18. 00	Ancillary services	75, 827, 5		75, 827, 542	18. 00
19. 00	Outpatient services	1 3, 321,	0 259, 560, 086		
20. 00	RURAL HEALTH CLINIC		0 0		20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES		0 4, 046, 624	4, 046, 624	23. 00
24.00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PHYSI CI AN		0 25, 562, 958		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to) Wkst. 106,042,3	336 289, 169, 668	395, 212, 004	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		450 007 (04	1	
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		152, 327, 631		29. 00
30.00	ADD (SPECIFY)		0		30.00
31. 00 32. 00			0		31.00
32.00			0		32. 00 33. 00
34. 00			0		34. 00
35. 00			0		35.00
36. 00	Total additions (sum of lines 30-35)				36.00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00	DEDUCT (GLEGITT)		Ö		38. 00
39. 00			Ö		39. 00
40. 00			o		40.00
41. 00			O		41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	152, 327, 631		43.00
	to Wkst. G-3, line 4)				

Health Financial Systems MARION	GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 150011	Peri od:	Worksheet G-3	
		From 07/01/2014 To 06/30/2015	Date/Time Prep 11/23/2015 7:	
			1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			395, 212, 004	1. 00
2.00 Less contractual allowances and discounts on patients' accounts			238, 702, 839	2.00
3.00 Net patient revenues (line 1 minus line 2)			156, 509, 165	3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)			152, 327, 631	
5.00 Net income from service to patients (line 3 minus lin	ne 4)		4, 181, 534	5. 00
OTHER I NCOME			0	/ 00
6.00 Contributions, donations, bequests, etc 7.00 Income from investments			0	6. 00 7. 00
	uni anti an annui ana		-8, 246, 320	7. 00 8. 00
8.00 Revenues from telephone and other miscellaneous commu 9.00 Revenue from television and radio service	inication services		0	8. 00 9. 00
10. 00 Purchase di scounts			0	9. 00 10. 00
11.00 Rebates and refunds of expenses			0	
12.00 Parking lot receipts			0	
13.00 Revenue from Laundry and Linen service			0	
14.00 Revenue from meals sold to employees and guests				14. 00
15.00 Revenue from rental of living quarters				15. 00
16.00 Revenue from sale of medical and surgical supplies to	o other than nationts			16. 00
17.00 Revenue from sale of drugs to other than patients	other than patrents			17. 00
18.00 Revenue from sale of medical records and abstracts				18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00
20. 00 Revenue from gifts, flowers, coffee shops, and cantee	en.		0	
21. 00 Rental of vending machines	211		0	
22. 00 Rental of hospital space			0	
23.00 Governmental appropriations			0	
24. 00 OTHER REVENUE			4, 256, 643	
25. 00 Total other income (sum of lines 6-24)			-3, 989, 677	
26. 00 Total (line 5 plus line 25)			191, 857	
27. 00 BAD DEBT EXPENSE			-2, 808	
28.00 Total other expenses (sum of line 27 and subscripts)			-2, 808	
29.00 Net income (or loss) for the period (line 26 minus li	ne 28)		194, 665	
	•	'		

	n Financial Systems MARION GENERAL			u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT	LATION OF CAPITAL PAYMENT	Provi der CCN: 150011	Peri od: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Pre 11/23/2015 7:	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			1, 105, 756	1.00
1. 01	'			0	1. 01
2. 00	0 Capital DRG outlier payments			6, 085	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00				50. 12	3.00
4. 00 5. 00	·			0. 00 0. 00	
6. 00	3 (0.00	6.00
5. 00	1.01) (see instructions)	e sum of filles I and 1.01	, corumns r and	O	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	, part A line	0. 00	7.00
	30) (see instructions)				
8. 00				0. 00	8.00
9. 00				0. 00	
10.00		s)		0.00	
11. 00 12. 00				0 1, 111, 841	11. 00 12. 00
12.00	Total prospective capital payments (see Histructions)			1, 111, 041	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0	3. 00 4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	
0.00	rotal impatient program capital cost (iiiie o x iiiie i)				0.00
				1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	 1.00
2. 00	Program inpatient capital costs (see Instructions)	cas (saa instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	ces (see mistraetrons)		0	3.00
4. 00	Applicable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6.00
7. 00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 x	: line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	8.00
9. 00 10. 00	Current year capital payments (from Part I, line 12, as appl		Loop lime ()	0	9. 00 10. 00
	Carryover of accumulated capital minimum payment level over			0	11.00
	Worksheet L, Part III, line 14)	. (1)	ıo 11)	0	12.00
11. 00		almonte (line 10 blue lib		U	
11. 00 12. 00	Net comparison of capital minimum payment level to capital p			n	12 00
11. 00 12. 00 13. 00	Net comparison of capital minimum payment level to capital p. Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over	r the amount on this line	e)	0	13. 00 14. 00
11. 00 12. 00 13. 00 14. 00	Net comparison of capital minimum payment level to capital p. Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	r the amount on this line capital payment for the f	e)	0	
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Net comparison of capital minimum payment level to capital p. Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see in	r the amount on this line capital payment for the f	e)	-	14. 00