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

(Si gned)

Officer or Administrator of Provider(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 Hospital	0	-193, 279	-76, 889	0	-398, 614	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	36, 076	0		19, 330	3.00
4.00 SUBPROVIDER I						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	-157, 203	-76, 889	0	-379, 284	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.

laws and regulations.

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	۹ ا	Provi der	CCN: 15-0011	Period: From 07/C	1/2010		ieet S-2	2
							0/2018	Date/T	ime Pre	
	1.00	2.00		3.0	0		4.00	11/25/	2019 10	<u>): 38</u>
	Hospital and Hospital Health Care Co		<u> </u>		0		4.00			
	Street: 441 WABASH AVENUE	P0 Box:								1.
0	City: MARION	State: IN		p Code: 4		ounty: GRANT	Davin		tam (D	2.
		Component Name			BSA Provi mber Typ			ent Sys , 0, or		
					51		V		XIX	1
		1.00	2	2.00 3	. 00 4. 0	0 5.00	6.00	7.00	8.00	
0	Hospital and Hospital-Based Componen	<u>t Identification:</u> MARION GENERAL HOS		50011 99	9915 1	07/01/19	56 N	Р	0	3.
	Hospital Subprovider - IPF	MARION GENERAL HUS	PTTAL TO	9	7915 1	077017190				4.
	Subprovider - IRF	MARION GENERAL HOS REHAB	PITAL 15	5T011 99	9915 5	07/01/200	05 N	P	0	5.
0	Subprovider - (Other)									6.
	Swing Beds – SNF Swing Beds – NF									8.
	Hospital-Based SNF									9.
	Hospital-Based NF									10.
	Hospital-Based OLTC									11.
	Hospital-Based HHA Separately Certified ASC									12.
	Hospi tal -Based Hospi ce									14.
00	Hospital-Based Health Clinic - RHC									15.
	Hospital -Based Health Clinic - FQHC									16.
	Hospital-Based (CMHC) I Renal Dialysis									17.
	Other									19
						Fro			0:	_
20	Cost Reporting Period (mm/dd/yyyy)					07/01			00)/2019	20.
	Type of Control (see instructions)					2		00/30	1 2017	20.
					1.00	2.0	00	3.	00	
00	Inpatient PPS Information Does this facility qualify and is it	currently receiving	ng navmer	nts for	Y	N				22.
	disproportionate share hospital adju									
	§412.106? In column 1, enter "Y" fo	r yes or "N" for n	o. Is thi	S						
	facility subject to 42 CFR Section §			ment						
01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un			for this	N	Y				22.
	cost reporting period? Enter in colu	mn 1, "Y" for yes o	or "N" fo	or no for		'				
	the portion of the cost reporting pe	riod occurring pri	or to Oct	tober 1.						
	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft									
02	is this a newly merged hospital that	•			N	N				22.
	payments to be determined at cost re	port settlement? (see instr	ructions)						
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob or "N" for no, for the portion of th				5					
	October 1.	s sost reporting p								
03	Did this hospital receive a geograph				N	N			N	22.
	rural as a result of the OMB standar				5					
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for	no for the portion	of the c	cost						
	reporting period occurring on or aft	•		,						
	Does this hospital contain at least counted in accordance with 42 CFR 41									
	yes or "N" for no.	2. TOOD: LITTER THE U	or anni 1 J,	1 101						
00	Which method is used to determine Me					3 N				23.
	below? In column 1, enter 1 if date									
	if date of discharge. Is the method reporting period different from the									
	reporting period? In column 2, ente									
			n-State	In-State		Out-of	Medi ca)ther	
			ledicaid aid days	Medicaio eligible		State Medi cai d	HMO da	-	di cai d days	
		þ	aru uays	unpai d	paid days	1			auys	
				days		unpai d				
			1.00	2.00	3.00	4.00	5.00		6.00	0 0 1
	If this provider is an IPPS hospital in-state Medicaid paid days in colum		707	1, 25	8	0 0	3,	121	(24.
00										
00	Medicaid eligible unpaid days in col	umn 2, I				·				
00	out-of-state Medicaid paid days in c	olumn 3,								
00		olumn 3, d days in column								

	Financial Systems MARION AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	I GENERAL HO ATA I	Provider CC	CN: 15-0011	Peri od:			eet S-2	
					From 07/0 To 06/3	30/2018	Date/T	ime Pre 2019 10	
		In-State Medicaid paid days	l n-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	aid (ays Me	Dther di cai d days	
		1.00	2.00	3.00	4.00	5.00		6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	174	0	0	0 Urban/I	Rural S	68 Date o	f Geogr	25.0
		<u> </u>				00	2.	00	
26.00 27.00 35.00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th	or rural. /age) status or "2" for r ication in	at the en ural. If a column 2.	d of the cos pplicable,	st	2 2 1			26.00 27.00 35.00
	effect in the cost reporting period.				Begi n	ni na:	Endi	i na:	
				0/ 5	1.	00	2.	00	
6. 00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		script line	36 for numb	ber 07/01	/2018	06/30)/2019	36.0
7.00	If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		er of perio	ds MDH statu	us	0			37.0
7. 01	Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)	he MDH trar or yes or "	nsitional p N" for no.	ayment in (see					37.0
8. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.0
						/N 00		/N 00	-
9.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (íi), or the mileage	′(iii)? En e requireme	ter in colur nts in	ume í nn	N		N	39.0
0.00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for			Y		Y	40.0
						V 1.00	XVIII 2.00	_	-
	Prospective Payment System (PPS)-Capital	nt for "	roncett	to observe '	000000		_	-	45 0
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)						N	N	45.0
6. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	st. L, Pt. I	II and Wks	t. L-1, Pt.	I through	N	N	N	46. C
	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals					N N	N N	N N	47.0 48.0
	Is this a hospital involved in training residents in	approved G	GME program	s? Enter "\	Y" for yes	N			56. C
8. 00	or "N" for no				approved				57.C
8. 00 6. 00	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "N oth of this Y", complet	l" for no i cost repor ce Workshee	n column 1. ting period´	If column ? Enter "	Y"			
8.00 6.00 7.00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim	or yes or "N oth of this Y", complet I, if appli obursement f	l" for no i cost repor ce Workshee cable. for physici	n column 1. ting period t E-4. lf co	If column ? Enter " olumn 2 is	Y"			58.0
8. 00 6. 00 67. 00 68. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "N hth of this Y", complet I, if appli bursement f complete W	l" for no i cost repor ce Workshee cable. For physici /kst. D-5.	n column 1. ting period ⁷ t E-4. If co ans' servico <u>, Pt. I.</u>	If column ? Enter " olumn 2 is es as	Y" N N			
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	or yes or "N hth of this Y", complet I, if appli bursement f complete W	l" for no i cost repor ce Workshee cable. For physici /kst. D-5.	n column 1. ting period´ t E-4. lf co ans' servico	If column ? Enter " olumn 2 is es as 35 Worksl	Y" N	Qualifi Crite	hrough ication erion	58.0 59.0
48.00 56.00 57.00 58.00 59.00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	r yes or "N th of this Y", complet I, if appli bursement f complete W s, complete	" for no i cost repor ce Workshee cable. Tor physici /kst. D-5. Wkst. D-2	n column 1. ting period t E-4. If co ans' servico , Pt. I. NAHE 413.8	If column ? Enter " olumn 2 is es as 35 Worksl Lin	Y" N N heet A	Qualifi Crite Cc	ication erion	59.0

ISPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider C		eriod: rom 07/01/2018 p 06/30/2019	Worksheet S-2 Part I Date/Time Pre 11/25/2019 10	epared
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	1
. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.(
	column 1. (see instructions)						
. 01	Enter the average number of unweighted primary care						61.
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						
	instructions)						
. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61.
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61.
	determining compliance with the 75% test. (see						
	instructions)						
. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.
	current cost reporting period. (see instructions).						
. 05	Enter the difference between the baseline primary						61.
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						
	61.04 minus line 61.03). (see instructions)						
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.
	care or general surgery. (see instructions)						
		Pro	ogram Name	Program Code	Unweighted	Unweighted	
					IME FTE Count	Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0.00	61.
	for each new program. (see instructions) Enter in						
	column 1, the program name. Enter in column 2, the						
	program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME						
	FTE unweighted count.						
. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0.00	0.00	61.
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
						1.00	
	ACA Provisions Affecting the Health Resources and Ser	rvi ces	Administration	n (HRSA)		1.00	-
00	Enter the number of FTE residents that your hospital	trai ne			iod for which	0.00	62.
01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a		ing Health Cer	ter (THC) into	vour bosnital	0.00	62
. 01	during in this cost reporting period of HRSA THC prog				your nospi tui	0.00	02.
~~	Teaching Hospitals that Claim Residents in Nonprovide				neni edo Fatera	N	
. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N	63.
			\	Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
				Si te	nospi tai	(01. 2))	
				1.00	2.00	3.00	ļ
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor		5	-This base year	is your cost	reporting	
00	Enter in column 1, if line 63 is yes, or your facilit			0.00	0.00	0. 000000	64.
	in the base year period, the number of unweighted nor	n-prima					
		oll					
	resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted						

				om 07/01/2018	Part I	
			To		Date/Time Pre	epare
	Program Name	Program Code	Unweighted	Unweighted	11/25/2019 10 Ratio (col.): 38
	r r ogr ann manie		FTEs	FTEs in	3/ (col . 3 +	
			Nonprovi der	Hospi tal	col. 4))	
	1.00	2.00	Si te	4.00	F 00	-
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000) 65
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te			
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	gsEffective f	or cost report	ing periods	
00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	occurring in all nonp unweighted non-prima	rovider settings. ry care resident	0.00	0.00	0. 000000	66.
(column 1 divided by (column 1 +						
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	Si te 3.00			
	1.00	2.00			F 00	-
00 Enter in column 1, the program			0.00	4.00	5.00 0.000000	0 67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						0 67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	PPS				0. 000000	0 67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	sychiatric Facility (0.00	0.00	0. 000000	70.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	sychiatric Facility (b. d the facility have a before November 15, 2 blumn 2: Did this fac FR 412.424 (d)(1)(iii	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	0.00 tain an IPF subp ing program in yes or "N" for i s in a new teacl yes or "N" for i	0.00 0.00 1.00 provider? N the most no. (see ning no.	0. 000000	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	r CCN: 15-0011	Period: From 07/01/20 To 06/30/20	018 Part 019 Date/	heet S-2 I Time Pre /2019 10	epared:
		-	1.00 2.0	0 3.00	-
6.00 If line 75 is yes: Column 1: Did the facility have an approved GME tea recent cost reporting period ending on or before November 15, 2004? Er no. Column 2: Did this facility train residents in a new teaching prog CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (nter "Y" for yes gram in accorda If column 2 is	n the most s or "N" for nce with 42 s Y,	N N	0	76.00
Long Term Care Hospital PPS			1	. 00	-
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" f 1.00 Is this a LTCH co-located within another hospital for part or all of t "Y" for yes and "N" for no. TEFRA Providers		ng period? En	ter	N N	80.00 81.00
 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? E 6.00 Did this facility establish a new Other subprovider (excluded unit) ur §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 	2		no.	N	85.00 86.00
7.00 Is this hospital an extended neoplastic disease care hospital classifi 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ed under section			Ν	87.00
		V 1.00		XI X 2. 00	-
Title V and XIX Services					
0.00 Does this facility have title V and/or XIX inpatient hospital services yes or "N" for no in the applicable column.				Y Y	90.00
 Is this hospital reimbursed for title V and/or XIX through the cost refull or in part? Enter "Y" for yes or "N" for no in the applicable col Are title XIX NF patients occupying title XVIII SNF beds (dual certifi 	umn.	N		r N	91.0
instructions) Enter "Y" for yes or "N" for no in the applicable column 3.00 Does this facility operate an ICF/IID facility for purposes of title N	1.	~ N		N	93.0
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" fo	or no in the	N		Ν	94.0
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable co 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.		0. 00 N	C	0. 00 N	95. 0 96. 0
 Approvable column. 7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or column 1 for title V, and in column 2 for title XIX. 	residents post	0. 00 Y	C). 00 Y	97. 0 98. 0
8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and title XIX.				Y	98.0
8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for for title V, and in column 2 for title XIX.		Y		Y	98.0
8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.				Ν	98.0
8. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed outpatient services cost? Enter "Y" for yes or "N" for no in column 1 in column 2 for title XIX.		N		Ν	98.0
8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 fo				Y	98.0
 column 2 for title XIX. 3. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for tit column 2 for title XIX. 		Y		Y	98.0
Rural Providers 05.00Does this hospital qualify as a CAH?		N			105.0
06.00 If this facility qualifies as a CAH, has it elected the all-inclusive for outpatient services? (see instructions)	method of paym				106.0
07.00 If this facility qualifies as a CAH, is it eligible for cost reimburse training programs? Enter "Y" for yes or "N" for no in column 1. (see i yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and th reimbursed. If yes complete Wkst. D-2, Pt. II.	nstructions) I				107.0
08.00 is this a rural hospital qualifying for an exception to the CRNA fee s	chedul e? See	42 N			108.0

Health Financial Systems MARION GENERAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	L HOSPITAL Provider C	CN: 15-0011 Pe	eriod:	LIEU	Workshe		2552-10 2
			om 07/01/		Part I Date/Ti		
					11/25/2	2019 10	
-	Physi cal 1.00	Occupational 2.00	Speec 3.00		Respir 4. (-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109.00
					1. (00	
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. I	f yes,	5	N	1	110.00
			1.00		2. (00	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained in the temperature of the FCHIP demonstration for this constrained integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for a constrained for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N				111.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	If column 2 nt for long te rs) based on 1	is "E", enter erm care (inclu che definition	in column des	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insur no.	rance? Enter '	Y" for yes or	"N" for	Y			117.00
118.00 the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is	1			118.00
		Premi ums	Losse	5	Insur	ance	
		1.00	2.00		3. (0	-
118.01 List amounts of malpractice premiums and paid losses:		1, 333, 414		0	3. (0118.01
			1.00		2. (0	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			N		2.0		118.02
19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment	ר column 1, " ualifies for ו	(" for yes or the Outpatient	N		N		119. 0 120. 0
Inter in column 3 "V" for yes or "N" for no							121.0
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no	antable device	es charged to	N				
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 	fined in §1903	3(w)(3) of the	N				122.0
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for 	fined in §1903 1 is "Y", ente	B(w)(3) of the er in column 2					
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, er 	Fined in §1903 1 is "Y", ente por yes and "N" hter the certi	3(w)(3) of the er in column 2	N				125. 0
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter and termination date, if applicable, in column 2. 	fined in §1903 1 is "Y", ente or yes and "N' nter the certi 2. ter the certi1	8(w)(3) of the er in column 2 for no. If fication date	N				125. 0 126. 0
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entir column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, entir column 1 and termination date, if applicable, in column 2 	Fined in §1903 I is "Y", enter for yes and "N" nter the certi 2. ter the certif 2. ter the certif	8(w)(3) of the er in column 2 for no. If fication date	N				125.0 126.0 127.0
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	Fined in §1903 1 is "Y", enter pr yes and "N" nter the certi 2. ter the certif 2. ter the certif 2.	3(w)(3) of the er in column 2 for no. If fication date fication date	N				125. 0 126. 0 127. 0 128. 0
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 	fined in §1903 1 is "Y", enter or yes and "N' nter the certi 2. ter the certif 2. er the certifi enter the certifi	8(w)(3) of the er in column 2 f for no. If fication date fication date fication date cation date in	N				125. 0 126. 0 127. 0 128. 0 129. 0
 21.00 Did this facility incur and report costs for high cost implationts? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified lung transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2 	Fined in §1903 1 is "Y", enter or yes and "N" nter the certif 2. ter the certif 2. ter the certif enter the cert umn 2. c, enter the cer	3(w)(3) of the er in column 2 for no. If fication date fication date fication date cation date in	N				125. 0 126. 0 127. 0 128. 0 129. 0 130. 0
 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyy) below. 26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified long transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified pancreas transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2. 	fined in §1903 1 is "Y", enter or yes and "N" hter the certif 2. ter the certif 2. ter the certifi enter the certifi umn 2. c, enter the certifi ter the certifi	3(w)(3) of the er in column 2 for no. If fication date fication date fication date cation date in rtification certification	N				125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00
 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, entir n column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified liver transplant center, entir n column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, entir n column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, entir n column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, entir n column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified long transplant center, enter column 1 and termination date, if applicable, in column 2 131.00 If this is a Medicare certified pancreas transplant center, enter in column 1 and termination date, if applicable, in column 2 	fined in §1903 1 is "Y", enter or yes and "N" neter the certif 2. ter the certif 2. ter the certifi enter the certifi umn 2. c, enter the certifi 2. ter the certifi 2.	(w) (3) of the er in column 2 for no. If fication date fication date cation date in rtification certification fication date	N				122. 00 125. 00 126. 00 127. 00 128. 00 130. 00 131. 00 132. 00 133. 00

Health Financial Systems	MARI ON GENERA	AL HOSPI TAL				In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provider CC	CN: 15-001			/01/2018 /30/2019	Worksheet S-2 Part I Date/Time Pre 11/25/2019 10	pared:
				-		1.00	2.00	
140.00 Are there any related organization o chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column 1. If ome office chain number	f yes, and home <u>f. (see instruc</u>	office c			N		140.00
1.00 If this facility is part of a chain	2.0		uah 143 t	he nam	ne and	3.00	of the home	
office and enter the home office con			ugii 145 t	The main		1 4001 633	of the nome	
141.00 Name: 142.00 Street: _143.00 City:	Contractor's Name: PO Box: State:		Contr Zip C	ractor' Code:	s Nur	nber:		141.00 142.00 143.00
							1.00	
144.00 Are provider based physicians' costs	included in Worksheet	Δ?					1.00 Y	144.00
144. oome provider based physicians costs	The dded Th worksheet	<u>N:</u>						144.00
						1.00	2.00	
145.00 If costs for renal services are clai inpatient services only? Enter "Y" f no, does the dialysis facility inclu period? Enter "Y" for yes or "N" fo 146.00 Has the cost allocation methodology	or yes or "N" for no ir de Medicare utilizatior r no in column 2. changed from the previc	n column 1. If n for this cost pusly filed cos	column 1 reportin t report?	g		N		145.00 146.00
Enter "Y" for yes or "N" for no in c yes, enter the approval date (mm/dd/	olumn 1. (See CMS Pub.							
							1.00	
147.00 Was there a change in the statistica								147.00
148.00 Was there a change in the order of a 149.00 Was there a change to the simplified				for n				148.00 149.00
147. Johnas there a change to the shipithed		Part A	Part			tle V	Title XIX	149.00
		1.00	2.00)		3.00	4.00	
Does this facility contain a provide or charges? Enter "Y" for yes or "N"		nent for Part A	and Part			2 CFR §41	3. 13)	
155.00Hospital 156.00Subprovider - IPF		N N	N N			N N		155.00 156.00
157. 00 Subprovi der – TRF		N	N N			N		157.00
158. 00 SUBPROVI DER								158.00
159.00 SNF		N	N			N		159.00
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N			N N		160.00 161.00
							N.	101.00
							1.00	
Multicampus 165.00 Is this hospital part of a Multicamp	us bespital that has on		usos in d	lifforo	nt CE	SAc2	N	165.00
Enter "Y" for yes or "N" for no.	us nospitai that has or	le or nore camp		lifiere		SAS (IN	165.00
	Name	County	State	Zip C		CBSA	FTE/Campus	
1// 00/ f line 1/F is yes far such	0	1.00	2.00	3.0	00	4.00	5.00	166.00
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	166.00
							1.00	
Health Information Technology (HIT)					Act			
167.00 Is this provider a meaningful user u 168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT	is "Y") and is a meanir	ngful user (lin			enter	the		167. 00 168. 00
168.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? E 169.00 If this provider is a meaningful use	nter "Y" for yes or "N"	for no. (see	instructi	ons)		-	0.00	168. 01 169. 00
transition factor. (see instructions			(1116-100	1.5 1	•), 6	inter the	0.00	107.00
						i nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR beg	inning date and ending	date for the r	eporti na			1.00 01/2015	2.00 09/30/2015	170.00
period respectively (mm/dd/yyyy)	5		. 5					

Health Financial Systems	MARI ON GENERAL	HOSPI TAL	In Lieu	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II	Period: From 07/01/2018	Worksheet S-	2		
			To 06/30/2019		epared:
				11/25/2019 1	<u>0:38 am</u>
			1.00	2.00	
171.00 If line 167 is "Y", does this provide	r have any days for indi	viduals enrolled in	N		0171.00
section 1876 Medicare cost plans repo					
"Y" for yes and "N" for no in column	1. If column 1 is yes, e	enter the number of secti	on		
1876 Medicare days in column 2. (see					

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-: Part II Date/Time Pro 11/25/2019 10	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ent	ter all dates in	the	_
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	begi nni ng of	the cost	N		1 1.0
	reporting period? If yes, enter the date of the change in c		instructions	5)		
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		Y	A		4.0
. 00	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	ilable in	N			5.0
. 00	those on the filed financial statements? If yes, submit rec					0.0
			•	Y/N	Legal Oper.	
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider i	s N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7.0 8.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal educatior	ר N		9.0
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		the current	N		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.0
				-	<u>Y/N</u> 1.00	
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. (13. (
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I	fyes, see ir	nstructions.	N	14. (
5.00	Did total beds available change from the prior cost reporti		yes, see ins t A	structions. Par	N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through data of the DS&P Depart used in columns 2 and 4 (cos	N		N		16. (
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	09/23/2019	Y	09/23/2019	17.
8, 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.0
2.00	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.					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		19.

HOSPI T	Financial Systems MARION GENERA		CN: 15-0011	Period:	u of Form CMS Worksheet S		
				From 07/01/2018 To 06/30/2019	Part II Date/Time P 11/25/2019		
		Descr	iption	Y/N	Y/N	10. 30 all	
			0	1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS	HOSPI TALS)			_	
22.00		e instructions				22.00	
23.00	Have changes occurred in the Medicare depreciation expense			ring the cost		23.00	
	reporting period? If yes, see instructions.			-			
	If yes, see instructions	0				24.00	
25.00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period	?If yes, see		25.00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	he cost report	ing period?	lfyes, see		26.00	
27.00		e cost reporti	ng period? I	fyes, submit		27.00	
28 00	Interest Expense Were new Loans, mortgage agreements or letters of credit er	ntered into du	ring the cos	t reporting		28.00	
29.00	period? If yes, see instructions.						
30.00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions				29.00	
	Has debt been recalled before scheduled maturity without is	5	5			31.00	
31.00	instructions. Purchased Services		debt: II ye	3, 366			
32.00	Have changes or new agreements occurred in patient care ser		ed through c	ontractual		32.00	
33.00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If		33.00	
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facility under an ar	rrangement wit	h provider-b	ased physi ci ans?		34.00	
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35.00	
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date		
				1.00	2.00		
	Home Office Costs						
	Were home office costs claimed on the cost report?	roparad by +	home office	2		36.00	
57.UU	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	NOME OTTICE	¢		37.00	
38.00	5			f		38.00	
39.00	If line 36 is yes, did the provider render services to othe see instructions.			s,		39.00	
40.00		home office?	lf yes, see			40.00	
			00		00		
	Cost Report Preparer Contact Information	1.	00	2.	00		
				SEVERS		41.00	
41. 00		TINA					
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		LLC			42.00	
42.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	TINA BLUE AND CO., 317-713-7946	LLC	TSEVERS@BLUEAN	DC0_C0M	42.00	

Heal th	Financial Systems MARION G	NERA	L HOSPI TAL		In Lieu	of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011		riod:	Worksheet S-2	2
				To	om 07/01/2018 06/30/2019	Date/Time Pre	pared.
					00/00/2017	11/25/2019 10) <u>: 38 am</u>
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	٨	/ANAGER				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						42.00
	preparer.						
43.00	Enter the telephone number and email address of the co	st					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	MARION GENERA	Provider C	CN: 15 0011	Period:	u of Form CMS-2 Worksheet S-3	
HUSPI	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der Co	UN: 15-0011	From 07/01/2018	Part I	
					To 06/30/2019	Date/Time Pre	
						11/25/2019 10	:38 am
						I/P Days / O/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	oomporterre	Line Number	No. of Deus	Avai I abl e	or an inclusion	in the v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	87	31, 7	55 0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		87	31, 7	55 0.00	0	7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	19	6, 9:	35 0.00	0	8.00
8.00 9.00	CORONARY CARE UNIT	31.00	17	0, 7.	0.00	0	9.00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		106	38, 69	90 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0	0	16.00
17.00	SUBPROVIDER - IRF	41.00	18		70	0	17.00
18.00	SUBPROVIDER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00 22.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.00
24.00	HOSPICE						23.00
24.00	HOSPICE (non-distinct part)	30.00					24.00
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		124				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33.00 33.01
JJ. UI	LTCH site neutral days and discharges	I I		I	I	1	1 33.01

HOSPI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	MARION GENERAL	Provi der CC	CN: 15-0011	Per	ri od:	u of Form CMS-2 Worksheet S-3	
					Fro	om 07/01/2018	Part I	
					То	06/30/2019	Date/Time Pre	
			/ O/P Visits	/ Tripc		Full Time E	11/25/2019 10	:38 am
		T/P Days	/ U/P VISILS	/ mps			qui vai entis	
	Component	Title XVIII	Title XIX	Total All	Т	otal Interns	Employees On	
	•			Patients		& Residents	Payrol I	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 955	707	13, 51	14			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)	3, 438	4, 379					2.00
3.00	HMO I PF Subprovi der	0	0					3.00
4.00	HMO I RF Subprovi der	406	68					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	5 055	0	40 5	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5, 955	707	13, 51				7.00
8.00	INTENSIVE CARE UNIT	1, 175	0	3, 74	49			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	7 400	0	1, 91			(05.04	13.00
14.00	Total (see instructions)	7, 130	707	19, 17		0.00	695.21	
15.00	CAH visits	0	0		0	0.00	0.00	15.00
16.00	SUBPROVIDER - IPF	0	0	2.07	0	0.00	0.00	1
17.00	SUBPROVIDER - IRF	2, 091	174	2, 82		0.00	15.69	
18.00 19.00	SUBPROVI DER SKI LLED NURSI NG FACI LI TY		0		0	0.00	0.00	18.00 19.00
20.00	NURSING FACILITY							20.00
20.00	OTHER LONG TERM CARE							20.00
21.00	HOME HEALTH AGENCY							21.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24.10	HOSPICE (non-distinct part)			,	66			24.10
25.00	CMHC - CMHC			(00			25.00
26.00	RURAL HEALTH CLINIC							26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0, 00	0.00	26.25
27.00	Total (sum of lines 14-26)	0	0		Ŭ	0.00	710.90	
28.00	Observation Bed Days		1, 019	3, 39	93	0.00	710.70	28.00
29.00	Ambulance Trips	1, 349	., ,	0,0				29.00
30.00	Employee discount days (see instruction)	., 517		14	40			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	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						33.00
22 01	LTCH site neutral days and discharges	0						33.01

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0011	Period: From 07/01/2018 To 06/30/2019		
	Full Time Equivalents		Di s	charges		
Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers 11.00	12.00	13.00	14.00	Patients 15.00	
.00 Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00				1.00
 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 8.00 HMO IPF Subprovider 9.00 Hospital Adults & Peds. Swing Bed SNF 9.00 Hospital Adults & Peds. Swing Bed SNF 9.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 OCRONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 3.00 NURSERY 4.00 Total (see instructions) 5.00 CAH visits 6.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER ALRE 9.00 SKILLED NURSING FACILITY 9.00 OTHER LONG TERM CARE 9.00 AMBULATORY SURGICAL CENTER (D.P.) 4.00 HOSPICE (non-distinct part) 	0.00 0.00 0.00 0.00		0 1, 8 0 2	0 0	4, 850 0 276 0	$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 20. \ 00\\ 20. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 22. \ 00\\ 24. \$
 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 	0. 00 0. 00					25.0 26.0 26.2 27.0 28.0
 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 						29. (30. (31. (32. (32. (
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges				0		33. (33. (

SPI T	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 07/01/2018 o 06/30/2019	Date/Time Pre	epare
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	11/25/2019 10 Average Hourly Wage (col. 4 ÷ col. 5)	: 38
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							
0	Total salaries (see	200.00	46, 401, 926	19, 581, 892	65, 983, 818	2, 048, 780. 00	32. 21	1
0	instructions) Non-physician anesthetist Part		0	O	0	0.00	0.00	2
0	A Non-physician anesthetist Part		0	C	о	0.00	0.00) 3
0	B Physician-Part A -		524, 819	C	E24 910	2, 796. 00	197 70	
0	Administrative		524, 619		524, 819			
1 0	Physicians - Part A - Teaching Physician and Non		0		-	0.00 0.00		
	Physician-Part B		-	-	_			
0	Non-physician-Part B for hospital-based RHC and FQHC services		0	O	0	0.00	0.00	6
0	Interns & residents (in an approved program)	21.00	0	O	0	0.00	0.00	7
1	Contracted interns and residents (in an approved		0	O	0	0.00	0.00	7
0	programs) Home office and/or related		0	C	0	0.00	0.00) e
0	organization personnel SNF	44.00	0	C	о	0.00	0.00	9
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		9, 015, 818	15, 994, 520	25, 010, 338	635, 194. 00	39. 37	10
00	Contract Labor: Direct Patient		7, 957, 013	C	7, 957, 013	226, 064. 00	35. 20	11
00	Care Contract Labor: Top Level		0	, o	0	0.00	0.00	12
	management and other management and administrative services					0.00		
00	Contract Labor: Physician-Part		227, 888	C	227, 888	1, 285. 00	177.34	13
00	A - Administrative Home office and/or related organization salaries and		0	C	0	0. 00	0.00	14
01	wage-related costs Home office salaries		0	C	о	0.00	0.00	14
02	Related organization salaries		0	0	0	0.00	0.00	14
00	Home office: Physician Part A - Administrative		0	Ŭ	0	0.00	0.00	115
00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	C	0	0.00	0.00	16
00	Wage-related costs (core) (see		13, 721, 295	0	13, 721, 295			17
00	instructions) Wage-related costs (other) (see instructions)		0	C	0			18
00	Excluded areas		7, 301, 330	0	7, 301, 330			19
	Non-physician anesthetist Part A		0	C	0			20
00	Non-physician anesthetist Part B		0	0	0			21
00	- Physician Part A - Administrative		100, 671	O	100, 671			22
	Physician Part A - Teaching		0	C	0			22
	Physician Part B Wage-related costs (RHC/FQHC)		0		0			23
	Interns & residents (in an		0	0	0			25
50	approved program) Home office wage-related		0	C	0			25
51	(core) Rel ated organi zati on		0	C	0			25
52	wage-related (core) Home office: Physician Part A		Ω	C	n			25
	- Administrative - wage-related (core)		0					
53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	C	0			25

Health Financial Systems		MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provider C	1	Period: From 07/01/2018 Fo 06/30/2019		pared:
	Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
	Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Sal ari es	$(col.2 \pm col.$	Salaries in	(col. 4 ÷	
			(from Wkst.	3)	col. 4	col. 5)	
			A-6)				
	1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARI				í	í.		
26.00 Employee Benefits Department	4.00	800, 602					
27.00 Administrative & General	5.00	7, 712, 906					
28.00 Administrative & General under		1, 827, 352	0	1, 827, 352	2 13, 835. 00	132.08	28.00
contract (see inst.)							
29.00 Maintenance & Repairs	6.00	0	0	(0.00		29.00
30.00 Operation of Plant	7.00	663, 677	0	663, 67	34, 684. 00	19. 13	
31.00 Laundry & Linen Service	8.00	0	0		0.00		31.00
32.00 Housekeepi ng	9.00	0	0	(0.00		32.00
33.00 Housekeeping under contract		1, 254, 425	0	1, 254, 42	5 104, 011. 00	12.06	33.00
(see instructions)							
34.00 Dietary	10.00	1, 133		1, 13			34.00
35.00 Dietary under contract (see		288, 175	0	288, 175	5 21, 820. 00	13. 21	35.00
instructions)							
36.00 Cafeteria	11.00	0	0		0.00	0.00	36.00
37.00 Maintenance of Personnel	12.00	0	0	(0.00		37.00
38.00 Nursing Administration	13.00	1, 140, 489	-272, 982	867, 50	22, 075. 00	39.30	38.00
39.00 Central Services and Supply	14.00	125, 022	7, 990	133, 012	2 7, 785. 00	17.09	39.00
40.00 Pharmacy	15.00	2, 736, 855	-13, 185	2, 723, 670	71, 384. 00	38. 16	40.00
41.00 Medical Records & Medical	16.00	0	0	(0.00	0.00	41.00
Records Library							
42.00 Social Service	17.00	0	0	(0.00	0.00	42.00
43.00 Other General Service	18.00	0	0	(0.00	0.00	43.00

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2018 To 06/30/2019		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		49, 771, 878	19, 581, 892	69, 353, 77	0 2, 188, 446. 00	31.69	1.00
	instructions)							
2.00	Excluded area salaries (see		9, 015, 818	15, 994, 520	25, 010, 33	8 635, 194. 00	39.37	2.00
	instructions)							
3.00	Subtotal salaries (line 1		40, 756, 060	3, 587, 372	44, 343, 43	2 1, 553, 252. 00	28.55	3.00
	minus line 2)							
4.00	Subtotal other wages & related		8, 184, 901	0	8, 184, 90	1 227, 349. 00	36.00	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		13, 821, 966	0	13, 821, 96	6 0.00	31.17	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		62, 762, 927	3, 587, 372	66, 350, 29	9 1, 780, 601. 00	37.26	6.00
7.00	Total overhead cost (see		16, 550, 636	-32, 873	16, 517, 76	3 636, 364. 00	25.96	7.00
	instructions)							
		·			•		I	•

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL			In	Li eu	of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provi der	CCN: 1	5-0011	Period: From 07/01/2 To 06/30/2	2018 2019	Worksheet S-3 Part IV Date/Time Pre 11/25/2019 10	pared:
								Amount	
								Reported	
								1.00	
	PART IV - WAGE RELATED COSTS								
	Part A - Core List								
1 00	RETIREMENT COST 401K Employer Contributions							1 050 014	1 00
1.00								1, 252, 814	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrib Nongualified Defined Benefit Plan Cost (see							0	2.00
3.00								3, 570, 571	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins PLAN ADMINISTRATIVE COSTS (Paid to External							0	4.00
5.00	401K/TSA Plan Administration fees	organization)						0	5.00
5.00 6.00	Legal /Accounting/Management Fees-Pension Pla							1, 443, 266	5.00 6.00
7.00	Employee Managed Care Program Administration							1, 443, 200	7.00
7.00	HEALTH AND INSURANCE COST	1665						0	7.00
8.00	Heal th Insurance (Purchased or Self Funded)						1	0	8.00
8.00	Heal th Insurance (Self Funded without a Thir	d Party Administ	rator)					0	8.01
8.02	Heal th Insurance (Self Funded without a Third P							9, 656, 005	8.02
8.02	Heal th Insurance (Purchased)	arty Auministrat	01)					y, 030, 003 0	8.03
9.00	Prescription Drug Plan							0	9.00
10.00	Dental, Hearing and Vision Plan							0	10.00
11.00	Life Insurance (If employee is owner or bene	eficiary)						0	11.00
12.00	Accident Insurance (If employee is owner or							0	12.00
13.00	Disability Insurance (If employee is owner o							365, 693	13.00
14.00			V)					0,070	14.00
15.00	'Workers' Compensation Insurance	ion of bonion of a	<i>J</i> /					279, 734	15.00
16.00		ar, not the extr	aordi narv	accrua	l reauir	ed by FASB 10)6.	0	16.00
	Non cumulative portion)		J			, see a second sec			
	TAXES								
17.00	FICA-Employers Portion Only							4, 271, 131	17.00
18.00	Medicare Taxes - Employers Portion Only							0	18.00
19.00	Unemployment Insurance							13, 816	19.00
20.00	State or Federal Unemployment Taxes							0	20.00
	OTHER						·		
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost	Reported o	n line	s 1 thro	ugh 4 above.	(see	0	21.00
22.00	Day Care Cost and Allowances							0	22.00
	Tuition Reimbursement							270, 267	23.00
	Total Wage Related cost (Sum of lines 1 -23)							21, 123, 297	24.00
	Part B - Other than Core Related Cost								
25.00	OTHER							0	25.00

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0011	Peri od:	Worksheet S-3 Part V	
				From 07/01/2018 To 06/30/2019		pared:
					11/25/2019 10	
	Cost Center Description			Contract	Benefit Cost	
				Labor	0.00	
	DADT V Contract Labor and Dansfit Cost			1.00	2.00	
	PART V - Contract Labor and Benefit Cost	fication				
1.00	Hospital and Hospital-Based Component Identi Total facility's contract labor and benefit			7, 957, 013	21, 123, 297	1.00
2.00	Hospital	CUST		7, 957, 013	21, 123, 297	2.00
3.00	Subprovi der – IPF			1, 737, 013	21, 123, 277	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital -Based Health Clinic RHC					14.00 15.00
15.00 16.00	Hospital-Based Health Clinic FQHC Hospital-Based-CMHC					15.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00
. 51 00	1			1 01		

Heal th	Financial Systems MARION GE	ENERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0011	Peri od:	Worksheet S-1	0
				From 07/01/2018		
				To 06/30/2019	Date/Time Pre 11/25/2019 10	
					11/23/2019 10	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 colu	umn 3 divided by li	ine 202 colum	n 8)	0. 248195	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				21, 453, 016	
3.00	Did you receive DSH or supplemental payments from Medio					3.00
4.00	lfline 3 is yes, does line 2 include all DSH and/or su	upplemental paymen [.]	ts from Medic	ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental pay	yments from Medicai	i d		0	
6.00	Medicaid charges				86, 659, 231	6.00
7.00	Medicaid cost (line 1 times line 6)				21, 508, 388	7.00
8.00	Difference between net revenue and costs for Medicaid	program (line 7 min	nus sum of li	nes 2 and 5; if	55, 372	8.00
	< zero then enter zero)		· ·			
	Children's Health Insurance Program (CHIP) (see instruc	ctions for each lir	ne)			
9.00	Net revenue from stand-alone CHIP				0	
10.00	Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alor	ne CHIP (line 11 mi	inus line 9;	if < zero then	0	12.00
	enter zero)			<u>, </u>	<u> </u>	
12 00	Other state or local government indigent care program (1 1 2 . 00
13.00	Net revenue from state or local indigent care program				0	
14.00	Charges for patients covered under state or local indig	gent care program	(Not included	In lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 time)	c line 14)			0	15.00
16.00	State or local indigent care program cost (line 1 times Difference between net revenue and costs for state or l		o program (Li	no 15 minus line	-	
10.00	13; if < zero then enter zero)	iocai inuigent care			f U	10.00
	Grants, donations and total unreimbursed cost for Medic	caid CHIP and stat	te/local indi	ent care progra	ams (see	1
	instructions for each line)			gent care progra	1113 (300	
17.00	Private grants, donations, or endowment income restrict	ted to funding cha	rity care		0	17.00
18.00	Government grants, appropriations or transfers for sup				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state a			s (sum of lines	55, 372	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the en	ntiro facility	11, 547, 13	6 5, 925, 255	17, 472, 391	20.00
20.00	(see instructions)	Intre facility	11, 347, 13	0 5,925,255	17, 472, 391	20.00
21.00	Cost of patients approved for charity care and uninsure	ed discounts (see	2, 865, 94	1 5, 925, 255	8, 791, 196	21.00
21.00	instructions)		2,000,7	0,720,200	0,771,170	21.00
22.00	Payments received from patients for amounts previously	written off as	40	8 1, 816	2, 224	22.00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)		2, 865, 53	3 5, 923, 439	8, 788, 972	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for		yond a length	of stay limit	N	24.00
25 00	imposed on patients covered by Medicaid or other indige					25 00
25.00	If line 24 is yes, enter the charges for patient days b	peyona the Indigen	t care progra	n's length of	0	25.00
26 00	stay limit Total had dobt exponse for the entire bespital complex.	(soo instructions)	\ \		10 200 272	26 00
26.00	Total bad debt expense for the entire hospital complex	•			10, 388, 373	1
27.00	Medicare reimbursable bad debts for the entire hospital				624, 062	
27.01	Medicare allowable bad debts for the entire hospital co	umprex (see instruc	ctions)		960, 095	•
28.00	Non-Medicare bad debt expense (see instructions)	dobt overses (Inctruction	\ \	9, 428, 278	1
29.00	Cost of non-Medicare and non-reimbursable Medicare bad		Instructions)	2, 676, 084	1
30.00	Cost of uncompensated care (line 23 column 3 plus line				11, 465, 056	•
31.00	Total unreimbursed and uncompensated care cost (line 19	• prus rine 30)			11, 520, 428	1 31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARI ON GENERAL	L HOSPITAL Provider CO	CN: 15-0011 P	eri od:	u of Form CMS-2 Worksheet A	2552-10
				F T	rom 07/01/2018 o 06/30/2019	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	11/25/2019 10 Recl assi fi ed Tri al Bal ance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	000 (00	13, 395, 795			12, 398, 749	•
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	800, 602 7, 712, 906	20, 845, 350 27, 465, 350			21, 700, 532 35, 399, 578	
6.00	00600 MAI NTENANCE & REPAI RS	0	27,403,330	03, 170, 230	0	03, 377, 370	1
6.01	00601 CAFETERI A	0	0	0	1, 364, 623	1, 364, 623	•
6.02	00602 CAFETERIA 00700 OPERATION OF PLANT	0	0	0		0	6.02 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	663, 677 0	4, 558, 710 0	5, 222, 387 0	385, 562 388, 048	5, 607, 949 388, 048	
9.00	00900 HOUSEKEEPI NG	0	2, 908, 852	2, 908, 852	-379, 391	2, 529, 461	•
10.00	01000 DI ETARY	1, 133	1, 946, 552	1, 947, 685		555, 095	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 140, 489 125, 022	81, 353 287, 580			948, 860 420, 592	•
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 736, 855	8, 943, 251	11, 680, 106		3, 598, 414	•
	INPATIENT ROUTINE SERVICE COST CENTERS	_,,			-,,		
30.00	03000 ADULTS & PEDIATRICS	7,077,293	1, 632, 244			7, 772, 996	•
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	1, 993, 914	658, 020	2, 651, 934	-23, 763	2, 628, 171 0	31.00 40.00
40.00	04100 SUBPROVI DER – I RF	989, 097	813, 021	1, 802, 118	0	1, 802, 118	•
42.00	04200 SUBPROVI DER	0	0	0	0	0	1
43.00	04300 NURSERY	0	0	0	1, 116, 333	1, 116, 333	43.00
50.00	ANCILLARY SERVICE COST CENTERS	0	13, 083, 275	13, 083, 275	146, 048	13, 229, 323	50.00
51.00	05100 RECOVERY ROOM	0	13,003,273	003,273	140, 040	13, 229, 323	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 093, 043	3, 176, 485	6, 269, 528	-1, 161, 276	5, 108, 252	54.00
57.00	05700 CT SCAN	0	0	0	1,066,736	1,066,736	•
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 599, 630	0 1, 203, 516	0 1, 803, 146	546, 599 23, 729	546, 599 1, 826, 875	•
60.00	06000 LABORATORY	2, 261, 493	5, 770, 617	8, 032, 110		8, 010, 192	
60.01	06001 ONCOLOGY	1, 013, 129	617, 730	1, 630, 859		1, 630, 859	1
60.02	06002 RADI ATI ON ONCOLOGY	0	0	0	0	0	60.02
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 242, 250 1, 798, 496	910, 149 256, 418	2, 152, 399 2, 054, 914	1, 618	2, 154, 017 2, 054, 914	
69.00	06900 ELECTROCARDI OLOGY	793, 504	164, 114		64,774	1, 022, 392	•
69.01	06901 CARDI AC REHAB	145, 504	5, 038	150, 542	36, 191	186, 733	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07200 TMPL. DEV. CHARGED TO PATTENTS 07300 DRUGS CHARGED TO PATTENTS	0	0	0	8, 081, 692	8, 081, 692	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	273, 595	518, 911	792, 506		819, 737	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 913, 573	4, 936, 990	8, 850, 563	-47, 051	8, 803, 512	91.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 023, 608	169, 771	1, 193, 379	20, 911	1, 214, 290	95.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		0	0	0	0	113.00
118.00		39, 398, 813	114, 349, 092			153, 987, 642	
400.00	NONREI MBURSABLE COST CENTERS		45 5 (0	45 5 (0	00 500	44.450	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	15, 560 0	15, 560 0	28, 592 0		190.00 192.00
	19202 VI SI TOR MEALS	0	0	0	0		192.00
192.03	19203 GREAT BEGI NNI NGS/MATERNAL	91, 124	4, 673	95, 797	8, 503	104, 300	192.03
		0	0	0	0		192.04
	19205 OWNED PROPERTIES 19206 UROLOGY	0 339, 304	1, 298, 974 1, 013, 201	1, 298, 974 1, 352, 505		227, 367 1, 396, 534	
	19211 PARI SH NURSI NG	27, 240	16, 675	43, 915			192.08
	19212 BI OTERRORI SM GRANT	0	0	0	0		192.09
	19214 BREAST PUMPS	0	0	0	0		192.10
	19208 MGH EMERGENCY PHYSICIANS 19209 LUNG CENTER	0 126, 687	0 675, 595	0 802, 282	0 24, 449	0 826, 731	192.11 192.12
	19213 MGH EXPRESS	346, 017	479, 662			859, 262	•
	19210 MGH PHYS PRACT MGMT	963, 711	778, 748	1, 742, 459		1, 779, 098	•
	19215 MGH MARION SURGEONS	440, 875	1, 522, 555			2,025,687	•
	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	0 782, 973	1, 394, 165 2, 503, 699	1, 394, 165 3, 286, 672		1, 394, 165 3, 288, 353	
	19218 MGH FAIRM MED ASSOC	112, 161	241, 923			395, 500	•
	19219 MGH FMC MARI ON	273, 059	541, 833			847, 754	•
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD	0 341, 450	0 955, 641	0 1, 297, 091	0	0 1, 297, 091	193.00 193.01
	19302 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY	341, 450 237, 906	650, 948		-	962, 371	
	19303 MGH HOSPITALISTS	-8, 943	4, 350, 090			4, 341, 147	
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Health Financial Systems	MARI ON GENERAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC		Peri od:	Worksheet A	
				From 07/01/2018 To 06/30/2019		narod
				10 00/30/2019	11/25/2019 10	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
193. 04 19304 MGH MAR FAM PRACT	969, 146	2, 120, 897	3, 090, 04		-,,	
193. 05 19305 MGH FMC SWAYZEE	80, 062	169, 162	249, 22			
193. 06 19306 MGH PEDIATRIC CTR	233, 362	795, 304				
193. 07 19307 MGH SPECIALTY PHYS	64, 769	242, 527	307, 29			
193. 08 19308 MGH FMC CONVERSE	103, 809	221, 682	325, 49			
193.09 19309 MGH UPLAND HEALTH	477, 930	1, 289, 721	1, 767, 65			
193. 10 19310 MGH MGH WOMENS CTR	0	0		0		193. 10 193. 11
193. 11 19311 MGH_MGH_PSYCHLATRY 193. 12 19312 0B/GYN	558, 414	2 214 227	2 074 74	0		
193. 15 19315 MGH RIVER VIEW BLDG	558, 414	2, 316, 327	2, 874, 74	1 10, 279		193.12
193. 16 19316 MGH NEONATOLOGY	0	656, 500	656, 50		656, 500	
193. 18 19318 MGH WOUND CARE	0	22,067	22,06		22,067	
194. 00 07963 HEART FAILURE CLINIC	0	53, 741	53, 74		53, 741	
194. 01 07950 MOW	0	55,741	55,74			194.00
194. 02 07951 MENTAL HEALTH	0	0				194.02
194. 03 07952 ADVERTI SI NG	0	0		285, 794		
194. 04 07953 MGH WORK SOLUTIONS	333, 841	569, 670	903, 51			
194. 05 07954 MGH TAYLOR UNIVERSITY	21, 279	139, 582	160, 86			
194. 08 07957 MGH_SMMPBLDG	0	0		0 0		194.08
194. 09 07958 MGH AMBUCARE BLDG	0	ō		0 0		194.09
194.1007959 MGH 106 LYONS BLDG	0	6, 498	6, 49	в О		194.10
194. 11 07960 FAI RMOUNT	0	0		0 0	0	194.11
194. 12 07961 GAS CI TY	0	0		0 0	0	194.12
194. 13 07969 LYONS	0	0		0 0	0	194.13
194.1407964 WABASH	0	0		0 0	0	194.14
194. 15 07965 TOBACCO GRANT	49, 592	13, 641	63, 23	3 3, 664	66, 897	194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	26, 246	57, 403	83, 64	9 0	83, 649	194.16
194. 17 07967 HRSA OPIOLD PLANNING	11, 099	76, 936	88, 03	5 0	88, 035	
200.00 TOTAL (SUM OF LINES 118 through 199)	46, 401, 926	139, 544, 692	185, 946, 61	в О	185, 946, 618	200.00

CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (UF EXPENSES	Provider CCN: 15-0	0011 Period: From 07/01/2018	Worksheet A B
			To 06/30/2010	9 Date/Time Prepare
Cost Center Description	Adjustments	Net Expenses		11/25/2019 10:38
	(See A-8)	For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS	<u> </u>	1 1		
0 00100 NEW CAP REL COSTS-BLDG & FIXT	-17, 215			1.
0 00400 EMPLOYEE BENEFITS DEPARTMENT 0 00500 ADMINISTRATIVE & GENERAL	-3, 079, 955			4.
0 00600 MAINTENANCE & REPAIRS	-10,004,100			5.
00601 CAFETERI A	-11, 052			6.
02 00602 CAFETERI A	0			6.
0 00700 OPERATION OF PLANT	-188, 525			7.
0 00800 LAUNDRY & LINEN SERVICE	-3, 579			8.
00 00900 HOUSEKEEPI NG 00 01000 DI ETARY	870			9. 10.
00 01300 NURSING ADMINISTRATION	-25			13.
00 01400 CENTRAL SERVICES & SUPPLY	-896			14.
00 01500 PHARMACY	-20, 105	3, 578, 309		15.
INPATIENT ROUTINE SERVICE COST CENTERS				
00 03000 ADULTS & PEDIATRICS	-29, 660			30.
00 03100 I NTENSI VE CARE UNI T 00 04000 SUBPROVI DER - I PF	-878			31. 40.
00 04100 SUBPROVI DER – I RF	-83, 879	8		41
00 04200 SUBPROVI DER	0			42.
00 04300 NURSERY	0	1, 116, 333		43.
ANCI LLARY SERVICE COST CENTERS	4 055 444	44.070.077		
00 05000 0PERATING ROOM 00 05100 RECOVERY ROOM	-1, 355, 446	1		50. 51.
00 05400 RADI OLOGY-DI AGNOSTI C	-209, 159	-		54
00 05700 CT SCAN	0			57.
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	,		58
00 05900 CARDI AC CATHETERI ZATI ON	-66, 396			59
	-121, 496			60. 60.
01 06001 0NC0L0GY 02 06002 RADI ATI ON ONCOL0GY	-5, 202			60
00 06500 RESPIRATORY THERAPY	-547			65
00 06600 PHYSI CAL THERAPY	-148			66
00 06900 ELECTROCARDI OLOGY	-53, 983			69
01 06901 CARDI AC REHAB	-11			69
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			71.
00 07300 DRUGS CHARGED TO PATIENTS	0			73
OUTPATIENT SERVICE COST CENTERS				
00 09000 CLI NI C	-1, 020			90.
00 09100 EMERGENCY	-3, 411, 681	5, 391, 831		91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92 92
OTHER REIMBURSABLE COST CENTERS		0		72
00 09500 AMBULANCE SERVICES	-65, 089	1, 149, 201		95
SPECIAL PURPOSE COST CENTERS				
8.00 11300 INTEREST EXPENSE	0			113
8. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	-24, 809, 225	129, 178, 417		118
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44, 152		190
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192
2. 02 19202 VI SI TOR MEALS	0	0		192
2. 03 19203 GREAT BEGI NNI NGS/MATERNAL	0	104, 300		192
2. 04 19204 LI FELI NE	-109, 424			192
. 05 19205 0WNED_PROPERTIES . 06 19206 UROLOGY	-59, 053	227, 367 1, 337, 481		192 192
. 08 19200 DR02001 . 08 19211 PARI SH NURSI NG	-37,033	50, 867		192
. 09 19212 BI OTERRORI SM GRANT	0	0		192
2. 10 19214 BREAST PUMPS	0	0		192
11 19208 MGH EMERGENCY PHYSI CLANS	0	0		192
2. 12 19209 LUNG CENTER 2. 13 19213 MGH EXPRESS	-48, 229	778, 502 859, 262		192 192
2. 13 19213 MGH EXPRESS 2. 14 19210 MGH PHYS PRACT MGMT	-67, 944			192
15 19215 MGH MARI ON SURGEONS	-112, 963			192
. 16 19216 MGH MGH MED ONC	0			192
2. 17 19217 MGH FMC SOUTH	-338, 868	2, 949, 485		192
2. 18 19218 MGH FAI RM MED ASSOC	-27, 088			192
2. 19 19219 MGH FMC MARION	-61, 469			192
3. OO 19300 NONPALD WORKERS 3. O1 19301 MGH FMC NORTHWOOD	0	0 1, 297, 091		193 193
3. 02 19301 MGH FMC NORTHWOOD 3. 02 19302 MGH FMC GAS CITY	-144, 701			193
3. 03 19303 MGH HOSPI TALI STS	0			193
	0			193.

ealth Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BAL/	MARION GENERA	Provider CCN	15-0011	Peri od:	u of Form CMS-255 Worksheet A	02
Less test to the here of the here of the bit				From 07/01/2018		
				To 06/30/2019	Date/Time Prepa 11/25/2019 10:3	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6.00	7.00				
93.05 19305 MGH FMC SWAYZEE	-27, 472	246, 603				93.0
93.06 19306 MGH PEDIATRIC CTR	-66, 454					93.(
93.07 19307 MGH SPECIALTY PHYS	-24, 861	294, 592				93. (
93.08 19308 MGH FMC CONVERSE	0	325, 798				93. (
93.09 19309 MGH UPLAND HEALTH	0	1, 773, 125				93.
93.10 19310 MGH MGH WOMENS CTR	0	0				93.
93. 11 19311 MGH MGH PSYCHIATRY	0	0				93.
93. 12 19312 OB/GYN	0	2, 885, 020				93.
93.15 19315 MGH RIVER VIEW BLDG	0	0			19	93.
93.16 19316 MGH NEONATOLOGY	0	656, 500			19	93.
93.18 19318 MGH WOUND CARE	0	22, 067			19	93.
94.0007963 HEART FAILURE CLINIC	0	53, 741			19	94.
94.0107950 MOW	0	0			19	94.
94.0207951 MENTAL HEALTH	0	0			19	94.
94. 03 07952 ADVERTI SI NG	0	285, 794			19	94.
94.04 07953 MGH WORK SOLUTIONS	0	948, 567			19	94.
94.0507954 MGH TAYLOR UNIVERSITY	0	160, 861			19	94.
94.0807957 MGH SMMP BLDG	0	0			19	94.
94.0907958 MGH AMBUCARE BLDG	0	0			19	94.
94.1007959 MGH 106 LYONS BLDG	0	6, 498			19	94.
94. 11 07960 FAI RMOUNT	0	0			19	94.
94. 12 07961 GAS CI TY	0	0			19	94.
94. 13 07969 LYONS	0	0			19	94.
94. 14 07964 WABASH	0	0			19	94.
94.1507965 TOBACCO GRANT	0	66, 897			19	94.
94. 16 07966 HRSA NETWORK DEV PLANNING	0	83, 649			19	94.
194. 17 07967 HRSA OPI OLD PLANNI NG	0	88, 035			19	94.
200.00 TOTAL (SUM OF LINES 118 through 1	-25, 897, 751	160, 048, 867				00.

Heal th	Financial Systems		MARION GENERAL	L HOSPI TAL		In Lieu of For	m CMS-2552-10
RECLASS	SI FI CATI ONS			Provider CCN: 15	-0011 Period	: Workshe 7/01/2018	et A-6
						6/30/2019 Date/Ti	me Prepared: 019 10:38 am
		Increases				1172072	
	Cost Center	Line #	Sal ary 4.00	Other 5.00			
	2.00 A - SATELLITE OFFICE RECLASS	3.00	4.00	5.00			
1.00	ELECTROCARDI OLOGY	69.00	11, 615	3, 751			1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	74, 242	7, 452			2.00
	TOTALS		85, 857	11, 203			
	B - CAFETERIA RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	53, 432			1.00
2.00		<u> </u>	0	1, 364, 623			2.00
	TOTALS C - ADMIN DIRECTOR RECLASS		0	1, 418, 055			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	23, 763	0			1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	7,990	0			2.00
3.00	ADULTS & PEDIATRICS	30.00	179, 792	0			3.00
4.00	CARDI AC CATHETERI ZATI ON	59.00	23, 729	0			4.00
5.00	RESPI RATORY THERAPY	65.00	1, 618	0			5.00
6.00	ELECTROCARDI OLOGY	69.00	35, 610	0			6.00
7.00	CARDI AC REHAB	69.01	23, 729	0			7.00
8.00	AMBULANCE SERVICES	95.00	20, 911	0			8.00
9.00	GIFT, FLOWER, COFFEE SHOP &	190.00	28, 592	0			9.00
10.00	CANTEEN GREAT BEGINNINGS/MATERNAL	192.03	8, 503	0			10.00
11.00	PARI SH NURSI NG	192.08	3, 664	0			11.00
12.00	MGH EXPRESS	192.13	26, 139	0			12.00
13.00	TOBACCO GRANT	194.15	3, 664	0			13.00
	TOTALS		387, 704	— — — ō			
	D – ADVERTISING						
1.00	ADVERTI SI NG	1 <u>94.</u> 03	<u>171, 5</u> 34	11 <u>4, 2</u> 60			1.00
	TOTALS		171, 534	114, 260			
1 00	E - LEASED PROPERTY	1.00		00.017			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	30, 817			1.00
2.00 3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	112, 973 384, 054			2.00 3.00
4.00	HOUSEKEEPING	9.00	0	8, 325			4.00
5.00	DI ETARY	10.00	o	24, 906			5.00
6.00	OPERATING ROOM	50.00	0	146, 048			6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	301, 056			7.00
8.00	CT SCAN	57.00	0	21, 411			8.00
9.00	MAGNETIC RESONANCE IMAGING	58.00	0	24, 145			9.00
	(MRI)						
10.00		60.00	0	72, 542			10.00
11.00	ELECTROCARDI OLOGY	69.00	0	13, 798			11.00
12.00 13.00	CARDI AC REHAB CLI NI C	69. 01 90. 00	0	12, 462 27, 231			12.00 13.00
	PARI SH NURSI NG	192.08	0	3, 288			14.00
15.00	LUNG CENTER	192.12	o	24, 449			15.00
16.00	MGH EXPRESS	192.13	Ö	7,444			16.00
17.00	MGH PHYS PRACT MGMT	192.14	0	36, 639			17.00
18.00	MGH MARION SURGEONS	192.15	0	62, 257			18.00
19.00	MGH FMC SOUTH	192.17	0	348, 492			19.00
20.00	MGH FAIRM MED ASSOC	192. 18	0	41, 416			20.00
21.00	MGH FMC MARION	192.19	0	32, 862			21.00
22.00	MGH WORK SOLUTIONS	194.04	0	45,056			22.00
23.00 24.00	UROLOGY MGH FMC GAS CITY	192.06 193.02	0	44, 029 73, 517			23.00 24.00
24.00 25.00	MGH FMC SWAYZEE	193.02	0	24, 851			24.00
25.00 26.00	MGH PEDIATRIC CTR	193.05	0	49, 808			25.00
20.00	MGH SPECIALTY PHYS	193.00	0	12, 157			20.00
28.00	MGH FMC CONVERSE	193.08	0	307			28.00
29.00	MGH UPLAND HEALTH	193.09	0	5, 474			29.00
30.00	OB/GYN	193.12	0	10, 279			30.00
	TOTALS		0	2,002,093			
	F - PHARMACY RECLASS			0.000			
1.00	DRUGS_CHARGED_TO_PATIENTS			8,081,692			1.00
			0	8,081,692			
1 00	G - CT/MRI RECLASS	ET OO	E14 004	500 007			1.00
1.00 2.00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00 58.00	514, 994 256, 948	528, 887 263, 880			1.00
2.00	(MRI)	56.00	200, 940	203,000			2.00
	TOTALS	+	771, 942	792, 767			
	H - SHORT TERM DI SABI LI TY		, , , , , , , , , , , , , , , , , ,				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	19, 968			1.00
2.00	PHARMACY	15.00	О	13, 185			2.00
3.00	ADULTS & PEDIATRICS	30. 00	о	3, 317			3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 344			4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	5, 395			5.00

	n Financial Systems SSIFICATIONS		MARION GENERAL	Provi der CCN: 15-001		u of Form CMS-2552 Worksheet A-6
(From 07/01/2018	
					To 06/30/2019	Date/Time Prepare
		Increases				11/25/2019 10:38
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
00	LABORATORY	60.00	4.00	1, 269		6.
00	RESPI RATORY THERAPY	65.00	0	2, 177		7.
00	EMERGENCY	91.00	0	2, 259		8.
00	MGH PHYS PRACT MGMT	192.14	0	272		9.
00	TOTALS	172.14	— — — <u>o</u>	49, 186		7.
	I - NURSERY RECLASS		U	49, 100		
00	NURSERY	43.00	969, 937	146, 396		1.
00	TOTALS	43.00	969, 937	146, 396		
	J - SMMP HOUSEKEEPING RECLASS		707, 737	140, 370		
00	ADMI NI STRATI VE & GENERAL	5.00	0	14, 618		1.
00	OPERATION OF PLANT	7.00	0	1, 508		2.
00	HOUSEKEEPING	9.00	0	332		3.
00	DI ETARY	10.00	0	559		4.
00	RADI OLOGY-DI AGNOSTI C	54.00	0	20, 683		5.
00	CT SCAN	57.00	0	1, 444		6.
00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 444		7.
00	(MRI)	56.00	U	1,020		/.
00	LABORATORY	60.00	o	2,600		8.
00	MGH FMC SOUTH	192.17	0	23, 190		9.
00	TOTALS	172.17	— — — o	2 <u>3, 140</u> 66, 560		7.
	K - LAUNDRY RECLASS	L	0	00, 500		
00	LAUNDRY & LINEN SERVICE	8.00		388, 048		1.
00	TOTALS	<u> </u>	— — — _d			1.
	L - PHYSICIAN MEDICAL DIRECTO		Ч	388, 048		
00			270 001	0		1
00	ADMI NI STRATI VE & GENERAL		370,001	<u>0</u>		1.
			370, 001	0		
00	M – PHYSICIAN RECLASS ADMINISTRATIVE & GENERAL	5.00	86, 950	0		1.
00	SUBPROVIDER – IRF	41.00		0		
			82, 070			2.
00		65.00	6, 738	0		3.
00	PHYSICAL THERAPY	66.00	3, 300	0		4.
00	CARDI AC REHAB	69.01	0	3, 600		5.
00		90.00	0	216		6.
00	EMERGENCY	91.00	3, 436, 120	0		7.
00	UROLOGY	192.06	588, 491	0		8.
00	LUNG CENTER	192.12	252, 271	0		9.
. 00	MGH EXPRESS	192.13	610, 808	0		10.
. 00	MGH MARION SURGEONS	192.15	1, 376, 745	0		11.
. 00	MGH MGH MED ONC	192.16	1, 390, 972	0		12.
3. 00	MGH FMC SOUTH	192.17	1, 959, 823	0		13.
. 00	MGH FAIRM MED ASSOC	192.18	164, 577	0		14.
. 00	MGH FMC MARION	192.19	407, 578	0		15.
. 00	MGH FMC NORTHWOOD	193.01	801, 044	0		16.
. 00	MGH FMC GAS CITY	193.02	402, 454	0		17.
	MGH HOSPI TALI STS	193. 03	2, 489, 758	0		18.
. 00	MGH MAR FAM PRACT	193.04	1, 573, 392	0		19.
		193.05	107, 537	0		20
. 00	MGH FMC SWAYZEE	175.05		0		21.
00	MGH FMC SWAYZEE MGH PEDIATRIC CTR	193.05	521, 401			
. 00 . 00 . 00	MGH PEDIATRIC CTR	193.06		0		
. 00 . 00 . 00 . 00	MGH PEDIATRIC CTR MGH SPECIALTY PHYS	193. 06 193. 07	204, 381			22.
. 00 . 00 . 00 . 00 . 00	MGH PEDIATRIC CTR MGH SPECIALTY PHYS MGH FMC CONVERSE	193. 06 193. 07 193. 08	204, 381 126, 324	0		22. 23.
. 00 . 00 . 00 . 00 . 00 . 00	MGH PEDIATRIC CTR MGH SPECIALTY PHYS MGH FMC CONVERSE MGH UPLAND HEALTH	193. 06 193. 07 193. 08 193. 09	204, 381 126, 324 906, 459	0		22. 23. 24.
. 00 . 00 . 00 . 00 . 00 . 00 . 00	MGH PEDIATRIC CTR MGH SPECIALTY PHYS MGH FMC CONVERSE MGH UPLAND HEALTH OB/GYN	193. 06 193. 07 193. 08 193. 09 193. 12	204, 381 126, 324 906, 459 1, 634, 245	0		22. 23. 24. 25.
 2. 00 3. 00 4. 00 4. 00 5. 00 	MGH PEDIATRIC CTR MGH SPECIALTY PHYS MGH FMC CONVERSE MGH UPLAND HEALTH OB/GYN MGH WOUND CARE	193. 06 193. 07 193. 08 193. 09 193. 12 193. 18	204, 381 126, 324 906, 459 1, 634, 245 22, 067	0 0 0 0 0		22. 23. 24. 25. 26.
3.00 9.00	MGH PEDIATRIC CTR MGH SPECIALTY PHYS MGH FMC CONVERSE MGH UPLAND HEALTH OB/GYN MGH WOUND CARE HEART FAILURE CLINIC	193. 06 193. 07 193. 08 193. 09 193. 12 193. 18 194. 00	204, 381 126, 324 906, 459 1, 634, 245 22, 067 38, 741	0 0 0 0 0		22. 23. 24. 25. 26. 27.
9.00 9.00	MGH PEDIATRIC CTR MGH SPECIALTY PHYS MGH FMC CONVERSE MGH UPLAND HEALTH OB/GYN MGH WOUND CARE HEART FAILURE CLINIC MGH WORK SOLUTIONS	193.06 193.07 193.08 193.09 193.12 193.18 194.00 194.04	204, 381 126, 324 906, 459 1, 634, 245 22, 067 38, 741 310, 423	0 0 0 0 0		22. 23. 24. 25. 26. 27. 28.
 0.00 0.00 00 	MGH PEDIATRIC CTR MGH SPECIALTY PHYS MGH FMC CONVERSE MGH UPLAND HEALTH OB/GYN MGH WOUND CARE HEART FAILURE CLINIC	193. 06 193. 07 193. 08 193. 09 193. 12 193. 18 194. 00	204, 381 126, 324 906, 459 1, 634, 245 22, 067 38, 741	0 0 0 0 0		22. 23. 24. 25. 26. 27.

CLASSI FI CATI ONS			Provider (CCN: 15-0011	Peri od:	Worksheet A-6
					From 07/01/2018 To 06/30/2019	Date/Time Prepared
	Decreases					11/25/2019 10:38 a
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· 	
6.00 A - SATELLITE OFFICE RECLASS	7.00	8.00	9.00	10.00		
DO LABORATORY	60.00	11, 615	3, 751		0	1.0
DO LABORATORY	60.00	74, 242	<u>7,452</u>		ō	2.0
TOTALS B - CAFETERIA RECLASS		85, 857	11, 203			
DI ETARY	10.00	0	1, 418, 055		0	1. (
	0.00	0	0		<u>o</u>	2.0
TOTALS C - ADMIN DIRECTOR RECLASS		0	1, 418, 055			
ADMI NI STRATI VE & GENERAL	5.00	43, 908	0		0	1. (
D NURSING ADMINISTRATION	13.00	272, 982	0		0	2.0
INTENSIVE CARE UNIT	31.00 91.00	23, 763 47, 051	0		0	3.0
	0.00	0	0		0	5.0
)	0.00	0	0		o	6.0
	0.00	0	0		0	7. (
	0.00	0	0		0	9.0
0	0.00	0	0		o	10.
	0.00	0	0		0	11.
	0.00	0	0		0	12.
TOTALS		387, 704	0		1	
D - ADVERTISING	5.00	474 504	444.040			
ADMI NI STRATI VE & GENERAL		<u>171, 5</u> 34 171, 534	<u>114, 260</u> 114, 260		<u>0</u>	1.0
E - LEASED PROPERTY			111/200			
NEW CAP REL COSTS-BLDG &	1.00	0	997, 046	1	0	1.0
FIXT OWNED PROPERTIES	192.05	0	1,005,047		0	2.
	0.00	Ő	0		0	3.
	0.00	0	0		0	4.
	0.00	0	0		0	5.
	0.00	Ő	0		0	7.
	0.00	0	0		0	8.
)0	0.00	0	0		0	9. 10.
	0.00	0	0		0	10.
00	0.00	0	0		o	12.
0	0.00	0	0		0	13.
	0.00	0	0		0	14.
00	0.00	0	0		0	16.
0	0.00	0	0		0	17.
0	0.00	0	0 0		0	18. 19.
0	0.00	0	0		o	20.
0	0.00	0	0		0	21.
	0.00	0	0		0	22. 23.
0	0.00	0	0		0	24.
0	0.00	0	0		0	25.
0	0.00	0	0		0	26. 27.
0	0.00	0	0		0	27. 28.
0	0.00	О	0		o	29.
0	0.00	0	<u>2,002,093</u>		0	30.
F - PHARMACY RECLASS		UU	2,002,093	1		
PHARMACY	15.00		8,081,692		0	1. (
TOTALS G - CT/MRI RECLASS		0	8, 081, 692	l		
RADI OLOGY-DI AGNOSTI C	54.00	771, 942	792, 767		0	1.0
	0.00	0	0		0	2.0
TOTALS H – SHORT TERM DI SABI LI TY		771, 942	792, 767			
ADMINISTRATIVE & GENERAL	5.00	19, 968	0		0	1.1
PHARMACY	15.00	13, 185	0		0	2.
ADULTS & PEDIATRICS	30.00	3, 317	0		0	3. (
) RADI OLOGY-DI AGNOSTI C) CARDI AC CATHETERI ZATI ON	54.00 59.00	1, 344 5, 395	0 0		0	4. (
D LABORATORY	60.00	1, 269	0		0	6.0
D RESPI RATORY THERAPY	65.00	2, 177	0			

-	SIFICATIONS		MARTON GENERA		CCN: 15-0011	Peri od:	Worksheet A-6
						From 07/01/2018 To 06/30/2019	Date/Time Prepared: 11/25/2019 10:38 am
		Decreases					1172372017 10.30 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Re	f.	
	6.00	7.00	8.00	9.00	10.00		
8.00	EMERGENCY	91.00	2, 259	0		0	8.00
9.00	MGH PHYS PRACT MGMT	1 <u>92.</u> 14	272	0		Q	9.00
	TOTALS		49, 186	0			
	I - NURSERY RECLASS					-	
1.00	ADULTS & PEDI ATRI CS		969,937	<u> </u>		Q	1.00
		<u> </u>	969, 937	146, 396			
1 00	J - SMMP HOUSEKEEPING RECLASS OWNED PROPERTIES	192.05	0	(/ E/O		0	1.00
1.00 2.00	OWNED PROPERTIES	0.00	0	66, 560 0		0	1.00
2.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
5.00		0.00	0	0		0	5.00
6.00		0.00	0	0		0	6.00
7.00		0.00	0	0		0	7.00
8.00		0.00	0	0		0	8.00
9.00		0.00	0	0		0	9.00
	TOTALS		0	66, 560			
	K - LAUNDRY RECLASS	·					
1.00	HOUSEKEEPI NG	9.00		388, 048		0	1.00
	TOTALS		0	388, 048			
	L - PHYSICIAN MEDICAL DIRECTO)R					
1.00	MGH FMC SOUTH	1 <u>92.</u> 17	37 <u>0, 0</u> 01	0		Q	1.00
	TOTALS		370, 001	0			
	M - PHYSICIAN RECLASS				1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	86, 950		0	1.00
2.00	SUBPROVIDER - IRF	41.00	0	82,070		0	2.00
3.00	RESPI RATORY THERAPY	65.00	0	6, 738		0	3.00
4.00 5.00	PHYSICAL THERAPY	66.00 69.01	2 (00	3, 300		0	4.00
5.00 6.00	CARDI AC REHAB CLI NI C	90.00	3, 600 216	0		0	5.00
7.00	EMERGENCY	90.00	210	3, 436, 120		0	7.00
8.00	UROLOGY	192.06	0	588, 491		0	8.00
9.00	LUNG CENTER	192.12	0	252, 271		0	9.00
10.00	MGH EXPRESS	192.12	0	610, 808		0	10.00
11.00	MGH MARION SURGEONS	192.15	0	1, 376, 745		o	11.00
12.00	MGH MGH MED ONC	192.16	0	1, 390, 972		0	12.00
13.00	MGH FMC SOUTH	192.17	0	1, 959, 823		0	13.00
14.00	MGH FAIRM MED ASSOC	192.18	0	164, 577		0	14.00
15.00	MGH FMC MARION	192.19	0	407, 578		0	15.00
16.00	MGH FMC NORTHWOOD	193.01	0	801, 044		0	16.00
17.00	MGH FMC GAS CITY	193.02	0	402, 454		0	17.00
18.00	MGH HOSPI TALI STS	193.03	0	2, 489, 758		0	18.00
19.00	MGH MAR FAM PRACT	193.04	0	1, 573, 392		0	19.00
20.00	MGH FMC SWAYZEE	193.05	0	107, 537		0	20.00
21.00	MGH PEDIATRIC CTR	193.06	0	521, 401		0	21.00
22.00	MGH SPECIALTY PHYS	193.07	0	204, 381		0	22.00
23.00	MGH FMC CONVERSE	193.08	0	126, 324		0	23.00
24.00	MGH UPLAND HEALTH	193.09	0	906, 459		0	24.00
25.00	OB/GYN	193.12	0	1, 634, 245		0	25.00
26.00	MGH WOUND CARE	193.18	0	22,067		0	26.00
27.00	HEART FAILURE CLINIC	194.00	0	38, 741		0	27.00
28.00	MGH WORK SOLUTIONS	194.04	0	310, 423		0	28.00
29.00	MGH TAYLOR UNIVERSITY	1 <u>94.</u> 05		130, 225		0	29.00
500.00	TOTALS Grand Total: Decreases		3,816	19, 634, 894		_	500.00
500.00	Dianu Tutai. Decreases	ļ	2, 809, 977	32, 655, 968	I	ļ	500. 00

MARION GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems

Health Financial Systems	MARI ON GENERA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0011	Period: From 07/01/2018 To 06/30/2019		pared:
			Acquisitions	8		
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Land	4, 646, 549	0	545, 28	545, 281	0	1.00
2.00 Land Improvements	3, 353, 531	0		0 0	0	2.00
3.00 Buildings and Fixtures	132, 355, 721	7, 303, 916		0 7, 303, 916	7,006	3.00
4.00 Building Improvements	3, 287, 381	263, 831		0 263, 831	0	4.00
5.00 Fixed Equipment	3, 176, 435	333, 095		0 333, 095		5.00
6.00 Movable Equipment	76, 530, 724	2, 292, 145		0 2, 292, 145	6, 085, 182	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	223, 350, 341	10, 192, 987	545, 28	31 10, 738, 268	6, 092, 188	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	223, 350, 341	10, 192, 987	545, 28	10, 738, 268	6, 092, 188	10.00
	Endi ng	Ful I y				
	Bal ance	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Land	5, 191, 830	0				1.00
2.00 Land Improvements	3, 353, 531	0				2.00
3.00 Buildings and Fixtures	139, 652, 631	0				3.00
4.00 Building Improvements	3, 551, 212	0				4.00
5.00 Fixed Equipment	3, 509, 530	0				5.00
6.00 Movable Equipment	72, 737, 687	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	227, 996, 421	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	227, 996, 421	0				10.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0011	Period: From 07/01/2018	Worksheet A-7 Part II	
					Date/Time Pre	pared:
					11/25/2019 10	<u>:38 am</u>
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	NN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	13, 395, 795	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	13, 395, 795	0		0 0	0	3.00
	SUMMARY O	F CAPI TAL				
Cost Center Description	Other	Total (1)				
	Capital -Relat					
	ed Costs (see	9 through 14)				
	instructions)	3 ,				
	14.00	15.00	1			
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	13, 395, 795				1.00
3.00 Total (sum of lines 1-2)	0	13, 395, 795				3.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2018 To 06/30/2019		pared:
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	l nsurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	223, 350, 342	0	223, 350, 34	2 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	223, 350, 342		223, 350, 34			3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 13, 395, 795		1.00
3.00 Total (sum of lines 1-2)	0	0		0 13, 395, 795	-997, 046	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	-17, 215	0		0 0	12, 381, 534	1.00
3.00 Total (sum of lines 1-2)	-17, 215	0		0 0	12, 381, 534	3.00

i al	Systems	MARI ON GENERAL HOSPI TAL

Heal th Financial

DJUSTMENTS TO EXPENSES		MARION GENERA	Provider CCN: 15-0011 P	eriod:	Worksheet A-8	
			F T	rom 07/01/2018 o 06/30/2019	Date/Time Pre 11/25/2019 10	pare
		-	Expense Classification on To/From Which the Amount is			
			TO/TTOIL WITCH THE AMOUNT TS	to be Aujusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2) 1.00	2.00	3.00	4.00	Ref. 5. 00	
00 Investment income - NEW CAP	1.00	10	NEW CAP REL COSTS-BLDG &	4.00	5.00	1.
REL COSTS-BLDG & FIXT (chapter 2)		F	FI XT			
00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0,	*** Cost Center Deleted ***	2.00	0	2.
00 Investment income - other (chapter 2)		0		0.00	0	3.
00 Trade, quantity, and time		0		0.00	0	4.
discounts (chapter 8) 00 Refunds and rebates of		О		0. 00	0	5.
expenses (chapter 8) 00 Rental of provider space by		0		0.00	0	6.
suppliers (chapter 8) 00 Telephone services (pay		0		0.00	0	7.
stations excluded) (chapter		0		0.00	0	
21) 00 Tel evi si on and radi o servi ce		0		0.00	0	8.
(chapter 21) 00 Parking lot (chapter 21)		0		0. 00	0	9.
.00 Provider-based physician adjustment	A-8-2	-5, 000, 946			0	10.
00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11
00 Related organization	A-8-1	0			0	12
transactions (chapter 10) 00 Laundry and linen service		О		0.00	0	
.00 Cafeteria-employees and guests .00 Rental of quarters to employee	В	-6, 824 0 0	CAFETERIA	6. 01 0. 00	0	
and others 00 Sale of medical and surgical		0		0.00	0	
supplies to other than		0		0.00	0	
patients .00 Sale of drugs to other than		о		0.00	0	17
patients 00 Sale of medical records and		0		0.00	0	18
abstracts 00 Nursing and allied health		0		0.00	0	19
education (tuition, fees, books, etc.)				0.00	0	
.00 Vending machines		0		0.00	0	
00 Income from imposition of interest, finance or penalty		0		0.00	0	21
charges (chapter 21) 00 Interest expense on Medicare		о		0.00	0	22
overpayments and borrowings to repay Medicare overpayments						
00 Adjustment for respiratory	A-8-3	OF	RESPI RATORY THERAPY	65.00		23
therapy costs in excess of limitation (chapter 14)						
00 Adjustment for physical therapy costs in excess of	A-8-3	OF	PHYSI CAL THERAPY	66.00		24
limitation (chapter 14) 00 Utilization review -		0,	*** Cost Center Deleted ***	114.00		25
physicians' compensation		0	bost bonton bonotou	111.00		
(chapter 21) OO Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26
COSTS-BLDG & FIXT OO Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2.00	0	27.
COSTS-MVBLE EQUIP 00 Non-physician Anesthetist		0,	*** Cost Center Deleted ***	19. 00		28.
00 Physi ci ans' assi stant	A 0 0	0		0.00	0	29.
.00 Adjustment for occupational therapy costs in excess of	A-8-3	0,	*** Cost Center Deleted ***	67.00		30.
limitation (chapter 14) 9.99 Hospice (non-distinct) (see		014	ADULTS & PEDIATRICS	30. 00		30.
i nstructi ons)						

Heal th	Financial Systems		MARION GENER	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
ADJUST	MENTS TO EXPENSES			F	Period: From 07/01/2018 To 06/30/2019	Worksheet A-8 Date/Time Pre 11/25/2019 10	epared:
				Expense Classification on To/From Which the Amount is		11/23/2017 10	
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	-	<u>(2)</u> 1.00	2.00	3.00	4.00	Ref. 5.00	
31.00	Adjustment for speech	A-8-3		*** Cost Center Deleted ***	68.00	5.00	31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest	٨		ADMINI STRATI VE & GENERAL	5.00		
33.00 33.01	ED ANESTHESIOLOGIST FINANCE BANK SERVICE CHARGES	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00		
33.02	FINANCE DI SCOUNT PAYMENTS	A		ADMI NI STRATI VE & GENERAL	5.00	(1
33.03	GALN ON DI SPOSAL	А		ADMINISTRATIVE & GENERAL	5.00	C	1
33. 04	XIX ASSESSMENT FEE A/C 7200.7892	A	-11, 709, 760	ADMINISTRATIVE & GENERAL	5.00	(33.04
33.05	SELF INSURANCE EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT		C	
33.06	RETURNED CHECK FEE	В		ADMINISTRATIVE & GENERAL	5.00	(
33. 07 33. 08	PHYSICIAN PRIV APPLIC SALE OF MEDICAL RECORDS &	B B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5. 00 5. 00	(
33. 09	ABSTRACTS CHILD SEAT SAFETY INSPECTION	В		ADMI NI STRATI VE & GENERAL	5.00	(
33.10	HEALTH SCREENING FEES - LAB	В			60.00	0	
33. 11 33. 12	HEALTH SCREENING FEES - RAD MED STAFF OTHER SCREENING-MED	B B		RADI OLOGY-DI AGNOSTI C ADMI NI STRATI VE & GENERAL	54.00 5.00	(
33. 13	STAFF FLU SHOT HEALTH SCREENS	В		ADMI NI STRATI VE & GENERAL	5.00	C	
33.14	HEALTH SCREENS	В		LABORATORY	60.00	0	
33. 15 33. 16	HEALTH SCREENS HEALTH SCREENS	B B		LABORATORY LABORATORY	60. 00 60. 00		
33.17	REBATE	В		ADMI NI STRATI VE & GENERAL	5.00	(1
33. 18	REBATE	В		ADMINISTRATIVE & GENERAL	5.00	C	
33. 19	RENTAL OF PROVIDER SPACE BY SUPPLIER	В		ADMI NI STRATI VE & GENERAL	5.00	C	
33.20	RENT SPACE UPLAND	В			60.00	(
33. 21 33. 22	PAGER RENTAL SALE OF SCRAP, WASTE, ETC,	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00		
33.23	SALE OF UNIFORMS	В		ADULTS & PEDIATRICS	30.00	(
33.24	PCC MARKETING AG	В		ADMINISTRATIVE & GENERAL	5.00	C	
33.25	EDUCATIONAL WORKSHOP	В		ADMI NI STRATI VE & GENERAL	5.00	(
33.26 33.27	OPT HEALTH LINEN SEV AMBULANCE SVC – ASSISTS	B B		LAUNDRY & LINEN SERVICE AMBULANCE SERVICES	8.00 95.00		
	AMBULANCE SVC - CORONER SVC	B		AMBULANCE SERVICES	95.00		33.28
33. 29	AMBULANCE SVC - LINEN SERVICES		-4, 224	AMBULANCE SERVICES	95.00		33.29
33. 30	AMBULANCE SVC - COMMUNITY EVENT STAF	В		AMBULANCE SERVICES	95.00		
33. 31	CONTRACT ARU OTH ARU MEDICAL DIRECTO	В	-61, 914	SUBPROVI DER – I RF	41.00	C	33.31
33. 32 33. 33	SCHOOL PHYS OTH SCHOOL PHYS PHLEBOTOMY	B B		ADMI NI STRATI VE & GENERAL LABORATORY	5. 00 60. 00	(
33.33 33.34	CPR TRAIN OTH AHA COMMUNITY	В		ADMI NI STRATI VE & GENERAL	5.00	(
33.35	CLINICAL STUDY- OTHER	В		ONCOLOGY	60. 01	(
33.36	SICK CHILD CARE PROGRAM	В		ADULTS & PEDIATRICS	30.00	C	
33.37	ONC. QUAL	B B		ADMI NI STRATI VE & GENERAL	5.00 5.00	(
33. 38 33. 39	SETTLEMENTS UNCLAIMED OTHER 125 MED/CHILD	B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5. 00 5. 00	(
33. 40	CARE E UNCLAIMED OTHER MONIES	В	0	CAFETERI A	6. 01	C	33.40
33. 41	RECOVERED VENDI NG MACHI NES	В	-4 228	CAFETERI A	6. 01	C	33.41
33. 42	MI SC REV	B		ADMI NI STRATI VE & GENERAL	5.00	(
	MISC REV	В		PHARMACY	15.00	C	
33.44	TELEVISION AND RADIO SERVICE	A		OPERATION OF PLANT	7.00	(
33.45 33.46	TELEPHONE SERVICE LOBBYING COSTS	A A		OPERATION OF PLANT ADMINISTRATIVE & GENERAL	7.00 5.00		
33.47	LOBBYI NG COSTS	A		NURSI NG ADMI NI STRATI ON	13.00	(
	LOBBYING COSTS	A	-387	PHARMACY	15.00	C	
33.49		A		ONCOLOGY	60.01	(
		A	0	RESPI RATORY THERAPY	65.00	0	33.50
33.50	LOBBYING COSTS LOBBYING COSTS	А		PHYSI CAL THERAPY	66.00	0	33.51

Health Fi	nancial Systems		MARION GENER	AL HOSPI TAL	In Lie	u of Form CMS-:	2552-10
ADJUSTMEN	NTS TO EXPENSES				Period:	Worksheet A-8	
					rom 07/01/2018		
					To 06/30/2019	Date/Time Pre 11/25/2019 10	
				Expense Classification or	Worksheet A	11/23/2017 10	. 50 am
				To/From Which the Amount is			
					, ,		
	Cont. Conton Decemination	Deel e (Cede	A	Cast Castan	1:	Wkst. A-7	
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #		
		(2) 1.00	2.00	3.00	4.00	Ref. 5.00	
33.53 EL	I MI NATI NG ENTRI ES	A		LI FELI NE	192.04	0.00	33.53
	LIMINATING ENTRIES	A		LUNG CENTER	192.12	0	33.54
	IMINATING ENTRIES	A		MGH MARION SURGEONS	192.15	0	
	IMINATING ENTRIES	А		MGH FMC SOUTH	192.17	0	33.56
33. 57 EL	IMINATING ENTRIES	А	-27, 088	MGH FAIRM MED ASSOC	192.18	0	33.57
33.58 EL	IMINATING ENTRIES	А	-61, 469	MGH FMC MARION	192.19	0	33.58
33.59 EL	IMINATING ENTRIES	A	-144, 701	MGH FMC GAS CITY	193.02	0	33.59
33.60 EL	IMINATING ENTRIES	A	-27, 472	MGH FMC SWAYZEE	193.05	0	33.60
33.61 EL	IMINATING ENTRIES	A		MGH PEDIATRIC CTR	193.06	0	33.61
33.62 EL	IMINATING ENTRIES	A	-59, 053	UROLOGY	192.06	0	33.62
	LIMINATING ENTRIES	A		MGH SPECIALTY PHYS	193.07	0	33.63
	IYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.64
	ITERTAI NMENT EXP	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.65
	MPLOYEE USE OF AUTO	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.66
	DNATI ONS	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.67
		A		EMPLOYEE BENEFITS DEPARTMEN		0	33.68
	IA OPPORTUNI TY IA OPPORTUNI TY	A A		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00	0	33.69 33.70
	A OPPORTUNI TY	A		HOUSEKEEPING	9.00	0	33.70
		A		DI ETARY	10.00		33.72
	A OPPORTUNI TY	A		CENTRAL SERVICES & SUPPLY	14.00	0	33.72
	A OPPORTUNI TY	A		PHARMACY	15.00	0	33.74
	A OPPORTUNI TY	А		ADULTS & PEDIATRICS	30.00	0	33.75
1	A OPPORTUNI TY	А		INTENSIVE CARE UNIT	31.00	0	33.76
33.77 VH	A OPPORTUNI TY	А	-205	SUBPROVIDER - IRF	41.00	0	33.77
33.78 VH	A OPPORTUNI TY	A	-31,045	OPERATING ROOM	50.00	0	33.78
33.79 VH	A OPPORTUNI TY	A	-12, 691	RADI OLOGY-DI AGNOSTI C	54.00	0	33.79
	IA OPPORTUNI TY	A		CARDIAC CATHETERIZATION	59.00	0	33.80
	A OPPORTUNI TY	A		LABORATORY	60.00	0	33.81
	A OPPORTUNI TY	A		ONCOLOGY	60.01	0	33.82
		A		RESPI RATORY THERAPY	65.00	0	33.83
		A		PHYSI CAL THERAPY	66.00	0	33.84
	IA OPPORTUNI TY IA OPPORTUNI TY	A		ELECTROCARDI OLOGY CARDI AC REHAB	69.00	0	33.85
		A		CLINIC	69.01		33.86
	IA OPPORTUNI TY IA OPPORTUNI TY	A		EMERGENCY	90.00 91.00	0	
	A OPPORTUNI TY	A		AMBULANCE SERVICES	91.00		
	O ON CALL SVC A/C 7000.2512	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	PERATING INTEREST INCOME	В		NEW CAP REL COSTS-BLDG &	1.00		
		2	17,210	FLXT	1.00		
33. 92 DE	EPOSI TI ON-OTHER	В	-2,000	ADMINISTRATIVE & GENERAL	5.00	0	33.92
50.00 TC)TAL (sum of lines 1 thru 49)		-25, 897, 751				50.00
	Fransfer to Worksheet A,						
CC	olumn 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems			MARI ON GENERAL HOSPI TAL			In Lieu of Form CMS-2552-10		
PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider CCN: 15-0011		eriod: Worksheet A-8-2 rom 07/01/2018 o 06/30/2019 Date/Time Prepared: 11/25/2019 10:38 am		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	KCL AMOUNT	ider Component	
		ruchthrei	Remarier attron	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		SUBPROVIDER - IRF	21, 760				0	1.00
2.00		ELECTROCARDI OLOGY	53, 655				0	2.00
3.00		OPERATING ROOM	1, 324, 401		(0	3.00
4.00		EMERGENCY	3, 409, 417				0	4.00
5.00		LABORATORY	11,000				0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	180, 713				0	6.00
7.00	0.00		0	0	(0	7.00
8.00	0.00		0	0	(0	8.00
9.00	0.00		0	0			0	9.00
10.00	0.00			0			0	
200.00			5,000,946	5,000,946			0	200.00
200100	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
			2	Limit	Continuing	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		SUBPROVIDER - IRF	0	0			0	1.00
2.00		ELECTROCARDI OLOGY	0	0	(0 0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	(0 0	0	3.00
4.00	91.00	EMERGENCY	0	0	(0 0	0	4.00
5.00	60.00	LABORATORY	0	0	(0 0	0	5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(ol	0	6.00
7.00	0.00		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	10.00
200.00			0	0	(0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	41.00	SUBPROVIDER - IRF	0	0	(21, 760		1.00
2.00	69.00	ELECTROCARDI OLOGY	0	0	(53, 655		2.00
3.00	50.00	OPERATING ROOM	0	0	(1, 324, 401		3.00
4.00	91.00	EMERGENCY	0	0	(3, 409, 417		4.00
5.00	60.00	LABORATORY	0	0	(11,000		5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(180, 713		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0 0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0 0		10.00
200.00			0	0	0	5, 000, 946		200.00
			•				-	

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0011			Period: From 07/01/2018 To 06/30/2019	Date/Time Prepar	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	<u>, 38 ar</u>
			1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS		1.00	1.00		0.00	
1.00 4.00 5.00 6.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	12, 381, 534 18, 620, 577 19, 315, 410	467, 893	19, 088, 470 2, 324, 407	23, 667, 711	23, 667, 711 0	1.0 4.0 5.0
6. 01	00601 CAFETERI A	1, 353, 571	163, 071	(-	262, 989	6.0
6. 02 7. 00 8. 00	00602 CAFETERIA 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 5, 419, 424 384, 469		(194, 424 (0 1, 544, 205 78, 969	
9.00	00900 HOUSEKEEPI NG	2, 530, 331		(457, 744	
10.00 13.00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON	555, 115 948, 835		332 254, 136		135, 276 212, 650	
	01400 CENTRAL SERVICES & SUPPLY	419, 696		38, 966	538, 670		
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	3, 578, 309	103, 073	797, 899	4, 479, 281	776, 716	15.0
30.00	03000 ADULTS & PEDIATRICS	7, 743, 336	1, 450, 347	1, 840, 848	3 11, 034, 531	1, 913, 410	30.0
	03100 I NTENSI VE CARE UNI T	2, 627, 293		577, 156		613, 993	
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	1, 718, 239	0 321, 811	(313, 798	-	0 408, 162	40.0
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 1, 116, 333	0	(284, 143) 0 3 1, 400, 476	0 242, 845	42.0 43.0
10.00	ANCILLARY SERVICE COST CENTERS				1		
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	11, 873, 877	1, 156, 739	(2, 259, 505 0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 899, 093	694, 520	701, 322	-	1, 091, 554	
57.00	05700 CT SCAN	1, 066, 736		150, 867		219, 897	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	546, 599		75, 273		118, 220	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 760, 479 7, 888, 696		181, 033 636, 981		366, 004 1, 554, 613	
60. 00 60. 01	06001 ONCOLOGY	1, 625, 657		296, 796		333, 357	
60. 02	06002 RADIATION ONCOLOGY	0		(0	
65.00	06500 RESPI RATORY THERAPY	2, 153, 470		365, 727		462, 770	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2,054,766		527, 836 246, 292		452, 957 256, 939	66. 0 69. 0
	06901 CARDI AC REHAB	968, 409 186, 722		48, 522		48, 343	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0,021		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(-	0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	8, 081, 692	0	(8, 081, 692	1, 401, 382	73.0
90.00	09000 CLINIC	818, 717	95, 083	80, 086	993, 886	172, 342	90.0
91.00	09100 EMERGENCY	5, 391, 831		2, 138, 647		1, 370, 254	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.0
92.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	92.0
95.00	09500 AMBULANCE SERVICES	1, 149, 201	139, 334	305, 992	2 1, 594, 527	276, 494	95.0
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	l .	[F	113.0
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	129, 178, 417			1		118.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	44, 152 0	44, 620 0	8, 376		16, 846 0	190. 0 192. 0
	19202 VI SI TOR MEALS	0	0	(o o		192.0
	19203 GREAT BEGI NNI NGS/MATERNAL	104, 300	0	29, 186	5 133, 486	23, 147	192.0
	19204 LI FELI NE	-109, 424		(192.0
	19205 OWNED PROPERTIES 19206 UROLOGY	227, 367 1, 337, 481		(271, 798	227,007	39, 426 279, 052	
	19211 PARI SH NURSI NG	50, 867		9, 053		10, 390	
192.09	19212 BI OTERRORI SM GRANT	0	0	(0	192.0
	19214 BREAST PUMPS	0	0	(192.1
	19208 MGH EMERGENCY PHYSICIANS 19209 LUNG CENTER	0 778, 502		111, 016	0 0 5 889, 518	0 154, 244	192.1 192.1
	19213 MGH EXPRESS	859, 262		287, 959		198, 930	
	19210 MGH PHYS PRACT MGMT	1, 711, 154		282, 239		345, 658	
	19215 MGH MARI ON SURGEONS	1, 912, 724	0	532, 472	2, 445, 196	424, 002	
	19216 MGH MGH MED ONC	1, 394, 165		407, 485		312, 410	
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	2, 949, 485 368, 412		695, 110 81, 070		631, 980 77, 941	
	19219 MGH FALRM MED ASSUC	786, 285		199, 393			
			0	(0 0		193.0

Health Financial Systems	MARION GENERA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	1	Provider CC		Period: From 07/01/2018 To 06/30/2019	Worksheet B Part I Date/Time Pre 11/25/2019 10	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> NEW BLDG & FI XT	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
	0	1.00	4.00	4A	5.00	
193.01 19301 MGH FMC NORTHWOOD 193.02 19302 MGH FMC GAS CITY 193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT	1, 297, 091 817, 670 4, 341, 147 3, 090, 043	0 0 0	334, 69 187, 59 726, 75 744, 83	1,005,2635,067,902	174, 315 878, 784	193. 02 193. 03
193.05 193.06 193.06 193.07 193.07 193.07 193.08 193.08 193.08 193.08	246, 603 1, 012, 020 294, 592	0 0 0	54, 95 221, 10 78, 84	57 301, 560 08 1, 233, 128 57 373, 439	52, 291 213, 827 64, 755	193. 05 193. 06 193. 07
193. 09 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH 193. 10 19310 MGH MGH WOMENS CTR 193. 11 19311 MGH MGH PSYCHLATRY	325, 798 1, 773, 125 0 0	0 0 0 0	67, 41 405, 55	7 2, 178, 682 0 0 0 0	377, 788 0 0	193. 09 193. 10 193. 11
193.12 193.15 19315 MGH RIVER VIEW BLDG 193.16 193.18 19318 MGH WOUND CARE	2, 885, 020 0 656, 500 22, 067	0 0 0	642, 33	0 0 0 656, 500	0 113, 838	193.15
194. 00 07963 HEART_FAILURE_CLINIC 194. 01 07950 MOW 194. 02 07951 MENTAL_HEALTH	53, 741 0	0 0 0 0	11, 34		11, 287 0	
194. 03 07952 ADVERTI SI NG 194. 04 07953 MGH WORK SOLUTI ONS 194. 05 07954 MGH TAYLOR UNI VERSI TY 194. 08 07957 MGH SMMP BLDG	285, 794 948, 567 160, 861 0	0 0 0 0	50, 25 188, 73 44, 38	1, 137, 304	197, 211 35, 590	194.04
194. 09 07958 MGH AMBUCARE BLDG 194. 10 07959 MGH 106 LYONS BLDG 194. 11 07960 FAI RMOUNT 194. 12 07961 GAS CI TY	0 6, 498 0 0	0 0 0 0		0 0 0 6, 498 0 0 0 0	1, 127 0	194.09 194.10 194.11 194.12
194. 13 07969 LYONS 194. 14 07964 WABASH 194. 15 07965 TOBACCO GRANT 194. 16 07966 HRSA NETWORK DEV PLANNING	0 0 66, 897 83, 649	0 0 0	15, 60 7, 68		0 14, 305	
194. 171707967HRSA OPIOID PLANNING200. 00Cross Foot Adjustments201. 00Negative Cost Centers202. 00TOTAL (sum Lines 118 through 201)	88, 035 160, 048, 867	0 0 12, 381, 534	3, 25	0 91, 286 0 0 0	15, 829	194. 17 200. 00 201. 00

	Financial Systems	MARION GENERA	Provi der CC		Period:	u of Form CMS-2 Worksheet B	2002-1
					From 07/01/2018 To 06/30/2019	Part I Date/Time Pre 11/25/2019 10	epared:
	Cost Center Description	MAINTENANCE &	CAFETERIA	CAFETERI A	OPERATION OF	LAUNDRY &): <u>38 an</u>
		REPAIRS 6.00	6. 01	6.02	PLANT 7.00	LINEN SERVICE 8.00	
	GENERAL SERVICE COST CENTERS	0.00	0.01	0.02	7.00	0.00	
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS	0					6.00
6.01		0	1, 779, 631	1 715 040	0		6.0
6.02 7.00	00602 CAFETERIA 00700 OPERATION OF PLANT	0	1, 715, 868 0	1, 715, 868 43, 930			6.02
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0, 475, 460	650, 135	
9.00	00900 HOUSEKEEPI NG	0	0		0 178, 589	0	
10.00		0	0	24		0	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	27, 98 9, 50		0 8, 787	
15.00	01500 PHARMACY	0	0	91, 60		0,707	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0	270, 393 82, 433		146, 007	
31.00 40.00	04000 SUBPROVIDER - IPF	0	0		3 548,915 D 0	33, 283 0	1
41.00	04100 SUBPROVI DER – I RF	0	Ō	41, 37	525, 085	18, 795	
42.00	04200 SUBPROVI DER	0	0	(o o	0	
43.00		0	0	39, 66	4 0	0	43.0
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0	244, 30	7 1, 887, 404	101, 461	50.0
51.00	05100 RECOVERY ROOM	0	Ő		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	118, 280		51, 631	
57.00	05700 CT SCAN	0	0	25, 23		21, 862	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERIZATI ON	0	0	12, 24 27, 75		0 7, 298	
50.00	06000 LABORATORY	0	0	111, 14		18	
50.01	06001 ONCOLOGY	0	0		o c	5, 248	60.0
60.02	06002 RADI ATI ON ONCOLOGY	0	0		0 0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	48, 13 31, 90		5, 584 17, 915	
69.00	06900 ELECTROCARDI OLOGY	0	0	44, 29		4, 812	
69.01	06901 CARDI AC REHAB	0	0	8, 15		0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0			0	
75.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		5 0	0	1 / 3. 0
90.00	09000 CLI NI C	0	0	11, 94		3, 207	
91.00	09100 EMERGENCY	0	0	173, 97	7 606, 491	193, 544	
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		o c	0	92.0 92.0
72.01	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	`	5 0	0	72.0
95.00	09500 AMBULANCE SERVI CES	0	0	62, 493	3 227, 345	26, 865	95.0
112 00	SPECIAL PURPOSE COST CENTERS	1					112 0
113.00 118.00)11300 INTEREST EXPENSE) SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 715, 868	1, 526, 79	9 10, 420, 683	646, 317	113.0
110.00	NONREI MBURSABLE COST CENTERS		1, 710, 000	1, 020, 17	10, 120, 000	010,017	1110.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1, 31	8 72, 805		190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.0
	2 19202 VI SI TOR MEALS 3 19203 GREAT BEGI NNI NGS/MATERNAL	0	63, 763 0				192.0 192.0
	19204 LI FELI NE	0	0	(0 0		192.0
	19205 OWNED PROPERTIES	0	0	(o o		192.0
	19206 UROLOGY	0	0	24, 18			192.0
	3 19211 PARI SH NURSI NG 9 19212 BI OTERRORI SM GRANT	0	0	1, 95			192.0 192.0
	19214 BREAST PUMPS	0	0	(0 0		192.1
192.11	19208 MGH EMERGENCY PHYSI CLANS	0	0	(0 0	0	192.1
	19209 LUNG CENTER	0	0	10, 67	1 0		192.1
	3 19213 MGH EXPRESS 1 19210 MGH PHYS PRACT MGMT	0	0	63, 86			192.1 192.1
	19215 MGH MARI ON SURGEONS	0	0	30, 42			192.1
92.16	5 19216 MGH MGH MED ONC	0	0		0 0	0	192.1
	19217 MGH FMC SOUTH	0	0	(0 0		192.1
	3 19218 MGH FAIRM MED ASSOC 9 19219 MGH FMC MARION	0	0) 21_02			192.1 192.1
	19219 MGH FMC MARTON 19300 NONPALD WORKERS	0	0	21, 02:			192. 1
	19301 MGH FMC NORTHWOOD	0	0				193.0
	2 19302 MGH FMC GAS CITY	0	О	(0 0		193.0
193 03	3 19303 MGH HOSPI TALI STS	0	0	(0 0		193.0
	19304 MGH MAR FAM PRACT						193.0

Heal th Finar	ncial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
					From 07/01/2018 To 06/30/2019		narod
					10 00/30/2019	11/25/2019 10	
	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	
	MGH PEDIATRIC CTR	0	0	18, 25			193.06
	MGH SPECIALTY PHYS	0	0	5, 55	0 0		193.07
	MGH FMC CONVERSE	0	0		0 0		193.08
	MGH UPLAND HEALTH	0	0		0 0		193.09
	MGH MGH WOMENS CTR	0	0		0 0		193.10
	MGH MGH PSYCHIATRY	0	0		0 0		193.11
193. 12 19312		0	0		0 0		193. 12
	MGH RIVER VIEW BLDG	0	0		0 0		193.15
	MGH NEONATOLOGY	0	0		0 0		193.16
	MGH WOUND CARE	0	0		0 0		193. 18
	HEART FAILURE CLINIC	0	0		0 0		194.00
194.0107950		0	0		0 0		194.01
	MENTAL HEALTH	0	0		0 0		194.02
	ADVERTI SI NG	0	0	7,75	4 0		194.03
	MGH WORK SOLUTIONS	0	0		0 0		194.04
	MGH TAYLOR UNIVERSITY	0	0		0 0		194.05
	MGH SMMP BLDG	0	0		0 0		194.08
	MGH AMBUCARE BLDG	0	0		0 0		194.09
	MGH 106 LYONS BLDG	0	0		0 0		194.10
194. 11 07960		0	0		0 0		194.11
194. 12 07961		0	0		0 0		194.12
194. 13 07969		0	0		0 0		194.13
194. 14 07964		0	0		0 0		194.14
	TOBACCO GRANT	0	0	2, 17			194.15
	HRSA NETWORK DEV PLANNING	0	0	1,40			194.16
	HRSA OPIOID PLANNING	0	0	48	6 0	0	194.17
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 779, 631	1, 715, 86	8 10, 493, 488	650, 135	202.00

COST ALLEGATION - GRIENA SERVICE COSTS Provider CR: 15-011 Privide (S)	Heal th	Financial Systems	MARI ON GENERAL	- HOSPI TAL		In Lieu	u of Form CMS-:	2552-10
Line Description Husselfer District Energy and an analysis Energy and analysis cost Centre Description Husselfer District				Provider C				
Cost Center Description HUBSERGP NR 9,00 91 FMP 1,00 WUBSEN Cost 1,2,00 CONTROL 1,2,00 PURSENCY 1,2,00 PURSENCY 1,2,00 1,00 COTONIC OF PERCECOST DELLES 1,00 1,0,00 1,0,00 1,4,00 1,0,00 1,4,00 1,0,00 0,00							Date/Time Pre	epared:
No. No. Supply 1 Suppl		Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG			
PURENT SPORT CONT CONT CONT OPERATES 90.00 10.00 13.00 14.00 15.00 4.00 DOUGO PERPENTER SENTETS DEPARTMENT 5.00 CONTROL STRATU CE A CLEMENT 4.00 4.00 6.00 DOUGO PERPENTER SENTETS DEPARTMENT 5.00 CONTROL STRATU CE A CLEMENT 5.00 6.00 6.00 DOUGO PERPENTERS 5.00 CONTROL STRATU CE A CLEMENT 5.00 6.00 6.00 DOUGO PERPENTERS S.270, 1177 1.330, 231 1.520, 177 66, 244 7.00 DOUGO PERATION OF PLANT S.100, 20 1.520, 177 66, 244 9.00 0.00 1.4, 00								
1.000 DUTOO MER CAP REC COST S-BLUG & FIXT 1.000			9.00	10.00			15.00	
4.00 Doubding HERP OFFE FRAFFITS OFFARTWENT 4.00 4.00 6.00 Doubding MAN ESTRATUR & ENFANLES 6.00 6.00 7.00 DOUDDING MAREY & LEMAN ESTRATUR 7.00 7.00 7.00 0.00 DOUDDING MAREY & LEMAN ESTRATUR 3.276 1.7.30 25.7 1.500 7.00 0.00 DIADO CENTRAL SERVICES & SUPPLY 7.7.340 0 1.500 17.340 1.500 1.500 1.500 1.500 1.400 1.400 1.400 1.500			<u>г</u>		1			1 1 00
5.00 DODOD ADMINI STRATUF & SCHERAL. 5.00 5.00 5.00 6.00								1
6 01 00001 CAFETERIA 6 02 00002 CAFETERIA 6 02 00002 CAFETERIA 6 02 00002 CAFETERIA 6 02 0000 DEPART IN 0 F PLANT 6 02 00 000 DEFART IN 0 F PLANT 6 02 00 000 DEFART IN 0 F PLANT 6 02 00 000 DEFART IN 0 F PLANT 6 02 00 000 DEFART IN 0 F PLANT 6 02 00 000 DEFART IN 0 F PLANT 6 02 00 00 00 DEFART IN 0 F PLANT 6 02 00 00 00 DEFART IN 0 F PLANT 0 F								1
6. D2 DEXCOL CAPTERTIA 7.00 000000000000000000000000000000000000								1
8.00 00000 LAURGY # 11 NET SERVICE 3, 2 / 6, 11 / 48, 223 1, 300, 21 / 48, 223 1, 500, 171 / 44, 203 1, 500 / 42, 203 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></td<>								1
9.00 00000 HOUSEKEEP NG 3.276,117 1,330,731 1,20,171 00000 HOUSEKEEP NG 3.276,177 1,300,731 1,200,171 00000 HOUSEKEEP NG 3.276,177 1,300,731 1,200,171 00000 HOUSEKEEP NG 3.276,177 1,300,731 10,000 HOUSEKEEP NG 3.276,177 1,200,174 4,217 HOUSEKEEP NG 3.276,177 1,200,174 4,217 HOUSEKEEP NG 4.276 1,276,177 1,200,174 4,217 HOUSEKEEP NG 4.276 1,276,278 1,276 1,277 1,200,174 1,278 1								1
10.00 01000 DETARY 14.82.22 1.330.253 1.50.77 0 10.00			3 276 117					1
14. 00 01400 CHITAL SERVICE & SUPPLY 75.348 0 0 855.264 1.00 IMARTERIT ROUTH SCHERD LODS CENTERS 0 0 0.557.978 15.00 16.00				1, 330, 251				1
15.00 00 01500 PARAMACY 42.195 0 0 5.57.97 15.00 10.01 00000 ADULTS & PEDIATRICS 6499.226 812.465 3648.292 33.451 0 31.00 10.01 001000 PEDIATRICS 6499.226 812.465 3648.292 33.451 0 31.00 10.01 001000 PEDIATRICS FEDIATRICS 649.226 34.451 0 0 41.00 10.01 01000 SUBROW IPER IFE 168.779 120.516 56.360 0 0 42.00 43.00 00000 00000 0 54.022 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
IDEADTIONT RAUTION SERVICE COST CENTERS 0 00 000000 01101 RFM TRICS 609, 226 812, 965 366, 293 119, 872 0 0 00000 01001 NTRICS 609, 226 812, 965 366, 293 119, 872 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>5 557 078</td><td>1</td></t<>							5 557 078	1
31. 00 03100 INTERSIVE CARE UNIT 192, 090 134. 302 112. 200 34. 251 0 31. 00 41. 00 04100 SUBRROW DER - I FF 168, 779 120. 516 56. 30 0 42. 00 42. 00 04200 SUBRROW DER - I FF 168, 779 120. 516 56. 30 0 42. 00 43. 00 04300 SUBRROW DER - I RF 0 0 54. 026 44. 03 0. 04300 UNINESSTOR 0 0 322, 766 51. 376 50. 00 0. 0 000 0 0 0 0 0 57. 00 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0 0. 0	-		42, 173	0	<u> </u>	0	5, 557, 770	13.00
40.00 42.00 42.00 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></th<>								1
11.00 0100 SUBPROVIDER - IRF 168, 779 120, 516 65, 300 8, 563 0 41.00 20.00 420, 00 420, 00 0 54, 020 0 44.00 420, 00 420, 00 00 54, 020 0 54, 020 0 42.00 420, 00 420, 00 00 53, 02 51, 376 0								1
43. 00 0 4300 NURSERY 0 0 54.022 0 43. 0 ANCLLARY SERVICE COST CENTERS 50.00 5000 OPERATING ROOM 0 0 51.00 50.00 60.00 <			-	-	-	-		1
AUCILIARY SERVICE COST CENTRES Image: Cost Centres 00 000000000000000000000000000000000000								1
50. 00 5500 (0) 6500 (0) 6500 (0) 6500 (0) 651. 376 0 51. 376 0 50. 00 54. 00 05400 (RADI CLOX"-DI ARMOSTI C 207. 960 0	-		0	0	54,026	0	0	43.00
54. 00 65400 (SA00) CRSCAN 207, 960 0 0 55. 00 57. 00 57. 00 57.00 0 <t< td=""><td>50.00</td><td>05000 OPERATING ROOM</td><td>446, 058</td><td>0</td><td>332, 766</td><td>51, 376</td><td>0</td><td>50.00</td></t<>	50.00	05000 OPERATING ROOM	446, 058	0	332, 766	51, 376	0	50.00
57. 00 05700 CT SCAN 0			-			-		1
58. 00 0 GBB00 MAGHETIC RESONANCE LIMAGING (MRI.) 0					-			1
60.00 06000 LABBATORY 168,779 0 0 51,376 0 60.00 60.01 06000 NOCLOCY 0 0 0 60.01 70.01				-	-			1
60.01 06C01 06C02 07C02 07C02 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td></th<>							0	
60. 02 06002 RADIATION ONCOLOGY 0<				-			-	
66.00 06600 PHYSICAL THERAPY 0 0 43, 451 0 0 66.00 99.00 66900 LECTROCATOLOLOCY B1, 375 0 0.337 25, 688 0 69.00 10.00 OTION DEDICAL SUPLIES CHARGED TO PATIENTS 0 0 0 0 77.00 10.00 OTION DEDICAL SUPCIES COST CENTERS 0 0 0 0 77.00 0.00 DEMERGENCY T23, 337 18, 384 236, 612 0<				-			-	1
69:00 06:900 ELECTROCARDIOLOCGY 81,375 0 60,337 25,688 0 69:00 69:01 71:00 07100 ICDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 77:00 77:00 77:00 77:00 0 0 0 0 0 0 0 0 0 0 0 0 0 77:00 77:00 0								
69 0				0		-		1
72.00 OZ200 IMPL DEV. CHARGED TO PATIENTS O O O 73.00 73.00 73.00 073000 0000000 CLINIC 0.00 </td <td>69.01</td> <td>06901 CARDI AC REHAB</td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td>69.01</td>	69.01	06901 CARDI AC REHAB		0			0	69.01
73.00 O O O O S5,57,978 73.00 90.00 OUTPATLENT SERVICE COST CENTERS 0 16,274 0						0		
90. 00 900.00 CLINIC 60, 278 0 16, 274 0 0 0 00 90.00 91.00 92.00						-	-	1
91:00 DIPOD ENERGENCY 723, 337 18, 384 236, 612 34, 251 0 91, 00 92, 01 93, 818 5, 557, 978 113, 00 113, 00 113, 00 113, 00 113, 00 114, 20 92, 01 92, 01 92, 01 92, 01 92, 01 92, 01 92, 01	-							
92.00 09200 0SERVATI ON BEDS (NON-DI STI NCT PART) 0<						-		1
OTHER REL MBURSABLE COST CENTERS 95.00 OPSOO AMBULANCE SERVICES 21,097 0 85,121 8,563 0 95.00 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 0 0 0 113.00 0 0 0 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 0 0 0 0 0 0 100.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 0 0 0 0 0 0 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 0 0 0 0 0 0 10.00 112.00 112.00 112.00 112.00 10.00 112.			723, 337	10, 304	230, 012	54, 251	0	1
95.00 09500 (AMBULANCE SERVICES 21,097 0 85,121 8,563 0 95.00 SPECIAL PURPOSE COST CENTERS Introduct Services Contress Introduct Services Cost Centers NONREL MBURSABLE COST CENTERS Introduct Services Contress Introduct Services Contres <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>92.01</td>			0	0	0	0	0	92.01
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 113.00 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 3,227,894 1,086,232 1,479,991 453,818 5,557,978 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 192.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.02 192.03 192203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.02 192.04 19204 LYSO4 0 0 0 0 192.02 192.05 19205 ONNED ROPERTIES 12,056 0 0 192.03 192.06 19206 UNED PROPERTIES 12,056 0 0 0 192.03 192.01 19211 PARISH NURSI NG 6,028 0 0 0 192.03 192.01 19212 IDTERORISM GRANT 0 0 0 0			21 097	0	85 121	8 563	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 227, 894 1, 086, 232 1, 479, 991 453, 818 5, 557, 978 118.00 NORE IMBURSABLE COST CENTERS 0<			21,077		00,121	0,000		/0.00
NONREI MBURSABLE COST CENTERS 0			0.007.004	1 00(000	1 170 001	450.040	E EEZ 070	
190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 6,028 0 0 0 0 190.00 192.00 19200 PHYSI CL ANS' PRI VATE OFFI CES 0 0 0 0 192.02 192.02 2V ISI TOR MEALS 0 0 0 0 0 192.02 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 6,798 0 0 192.03 192.04 19204 LI FELI NE 0 0 0 0 192.03 192.05 WINED PROPERTI ES 12,056 0 0 0 192.06 192.06 19205 WINED NROPERTI ES 12,056 0 0 0 192.06 192.08 19211 PARI SH NURSI NG 6,028 0 0 0 192.09 192.10 19212 BI OTERRORI SM GRANT 0 0 0 0 192.10 192.11 19209 LUNG CENTER 0 0 0 0 192.12 192.13 INGH EXPRESS 0 0 0 0<	-		3, 227, 894	1,086,232	1, 479, 991	453, 818	5, 557, 978	118.00
192.02 VI SI TOR MEALS 0 0 0 192.02 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 6,798 0 0 192.04 192.04 LI FELI NE 0 0 0 0 0 0 192.04 192.05 19205 OWNED PROPERTI ES 12,056 0 0 0 192.05 192.06 19206 IP206 UROLOGY 0 0 0 192.08 192.08 19211 PARI SH NURSI NG 6,028 0 0 0 192.09 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.09 192.09 19214 BREAST PUMPS 0 0 0 0 192.09 192.11 19208 MGH EMERGENCY PHYSI CI ANS 0 0 0 192.12 192.11 19208 MGH CENTER 0 0 0 192.12 192.13 19213 MGH PHYS PRACT MGMT 24, 111 0 0 0 192.15 192.14<	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 028			-		
192.03 IP203 GREAT BEGI NNI NGS/MATERNAL 0 0 6,798 0 0 192.03 192.04 19204 LI FELI NE 0 0 0 0 192.04 192.05 19205 OWNED PROPERTIES 12,056 0 0 0 192.05 192.06 IP206UC0GY 0 0 0 25,688 0 192.06 192.09 19211 PARISH NURSI NG 6,028 0 0 0 192.09 192.10 19214 BREAST PUMPS 0 0 0 0 192.09 192.11 19208 MGH EMERGENCY PHYSI CLANS 0 0 0 192.10 192.12 19209 LUNG CENTER 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 0 192.13 192.14 IP210 MGH MARI ON SURGEONS 0 0 0 192.15 192.16 19215 MGH MARI ON SURGEONS 0 0 0 192.16 192.17 19216 M			0			0		
192.04 19204 LI FELI NE 0 0 0 192.04 192.05 19205 OWNED PROPERTI ES 12,056 0 0 0 192.05 192.06 19206 UROLOGY 0 0 25,688 0 192.06 192.08 19211 PARI SH NURSI NG 6,028 0 0 0 192.09 192.09 19212 BI OTERRORI SM GRANT 0 0 0 192.09 192.10 19214 BREAST PUMPS 0 0 0 192.09 192.11 19209 LIM EGENCY PHYSI CI ANS 0 0 0 192.11 192.12 19209 LUNG CENTER 0 0 0 192.12 192.13 MGH EMERGENCY PHYSI CI ANS 0 0 0 192.13 192.13 IGCENTER 0 0 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 24,111 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 0			0	-	-	0		
192.06192.06UROLOGY025,6880192.06192.0819211PARI SH NURSI NG6,028000192.08192.0919212BI OTERRORI SM GRANT0000192.09192.1019214BREAST PUMPS0000192.10192.11IP208MGH EMERGENCY PHYSI CI ANS0000192.11192.1219209LUNG CENTER0000192.12192.1319213MGH EXPRESS000192.13192.1419215MGH MARI ON SURGEONS000192.14192.1519215MGH MARI ON SURGEONS000192.16192.1619216MGH MED ONC000192.16192.17IGH FMC SOUTH0000192.17192.1819218MGH FAI RM MED ASSOC000192.19193.0119301MGH FMC NARI ON000193.01193.0119303MGH FMC NORTHWOOD000193.03193.03193.03MGH HOSPI TALI STS000193.03	192.04	19204 LI FELI NE	0	0		0	0	192.04
192. 0819211PARI SH NURSI NG6,028000192. 08192. 0919212BI OTERRORI SM GRANT0000192. 09192. 1019214BREAST PUMPS0000192. 10192. 1119208MGH EMERGENCY PHYSI CI ANS0000192. 11192. 1219209LUNG CENTER0000192. 12192. 1319213MGH EXPRESS0000192. 13192. 1419210MGH MARI ON SURGEONS000192. 15192. 1519215MGH MGH MED ONC000192. 17192. 1619216MGH FAI RM MED ASSOC000192. 18192. 1919219MGH FAI RM MED ASSOC000192. 19193. 0119301MGH FMC MARI ON000193. 00193. 0119303MGH FAI RM MODD000193. 02193. 0319303MGH HOSPI TALI STS000193. 03			12, 056	0	0	0		
192.10 19214 BREAST PUMPS 0 0 0 192.10 192.11 19208 MGH EMERGENCY PHYSI CLANS 0 0 0 0 192.11 192.12 19209 LUNG CENTER 0 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 33,382 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 24,111 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.15 192.16 192.17 19216 MGH MED ONC 0 0 0 0 192.16 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 192.17 192.19 19219 MGH FAI RM MED ASSOC 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 0 193.02 193.02 19302 MGH FMC CAS			6, 028	0	0			
192.11 19208 MGH EMERGENCY PHYSI CLANS 0 0 0 192.11 192.12 19209 LUNG CENTER 0 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 33,382 0 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 24,111 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 0 192.16 192.16 19216 MGH MEL ONC 0 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 0 192.16 192.19 19218 MGF FAI RM MED ASSOC 0 0 0 0 192.19 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 192.19 193.00 19300 NONPAID 0 0 0 0 193.00 193.03 193.03 193.03 193.03 193.03 193.03 193.03 0 193.02			0	0	0	0		
192.12 19209 LUNG CENTER 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 33,382 0 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 24,111 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.15 192.16 19216 MGH MGH MED ONC 0 0 0 192.16 192.17 19217 MGH FKC SOUTH 0 0 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 192.19 19300 NONPAI D WORKERS 0 0 0 193.00 193.03 193.03 193.03 194.10 193.02 193.02 193.02 193.03 193.03 193.03 193.03 193.03 193.03 0 193.0			0	-	0	0		
192.13 19213 MGH EXPRESS 0 0 33,382 0 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 24,111 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 0 192.15 192.16 19216 MGH MGH MED ONC 0 0 0 0 192.16 192.17 19217 MGH FAC SOUTH 0 0 0 0 192.17 192.18 19219 MGH FAI RM MED ASSOC 0 0 0 0 192.18 192.19 19219 MGH FKC NARI ON 0 0 0 192.19 193.00 19300 NORPAI D WORKERS 0 0 0 193.01 193.02 19302 MGH FMC GAS CITY 0 0 0 193.02 193.03 193.03 193.03 193.03 193.03 0 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 193.03 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>192.12</td>			0	0	0	0	0	192.12
192.1519215MGH MARI ON SURGEONS00034, 2510192.15192.1619216MGH MED ONC0000192.16192.1719217MGH FMC SOUTH00034, 2510192.17192.1819218MGH FAI RM MED ASSOC0000192.18192.1919219MGH FMC MARI ON0000192.19193.0019300NONPAI D WORKERS000193.00193.0119301MGH FMC NORTHWOOD008, 5630193.02193.0319303MGH HOSPITALI STS0000193.03			-	0	33, 382	0	0	192.13
192.16 19216 MGH MED ONC 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 34,251 0 192.17 192.18 19218 MGH FALRM MED ASSOC 0 0 0 0 192.18 192.19 ISH FMC MARI ON 0 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 0 193.02 193.02 19302 MGH FMC GAS CITY 0 0 0 17, 125 0 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03			24, 111	0	0	0 34 251		
192.17 19217 MGH FMC SOUTH 0 0 34,251 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 0 193.02 193.02 193.02 19302 MGH FMC GAS CITY 0 0 0 17, 125 0 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03			0	0	0	0		
192.1919219MGH FMC MARI ON0017, 1250192.19193.0019300NONPAI D WORKERS0000193.00193.0119301MGH FMC NORTHWOOD0000193.01193.0219302MGH FMC GAS CITY00017, 1250193.02193.0319303MGH HOSPITALISTS00000193.03	192.17	19217 MGH FMC SOUTH	0	0	0	34, 251	0	192.17
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 0 8,563 0 193.01 193.02 19302 MGH FMC GAS CITY 0 0 0 17,125 0 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03			0	0	0	0 17 125		
193.01 19301 MGH FMC NORTHWOOD 0 0 8, 563 0 193.01 193.02 19302 MGH FMC GAS CITY 0 0 0 17, 125 0 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03			0	-	0	0		
193. 03 19303 MGH HOSPITALISTS 0 0 0 0 0 193. 03	193.01	19301 MGH FMC NORTHWOOD	0	0	0		0	193.01
				0	°,			
			0	0	-	-		

Health Financial Systems	MARION GENERAL	eu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet B Part I Date/Time Prepared: 11/25/2019 10:38 am
Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG ADMI NI STRATI N	CENTRAL D SERVI CES & SUPPLY	PHARMACY
	9.00	10.00	13.00	14.00	15.00
193.05 19305 MGH FMC SWAYZEE	0	0		0 17, 125	0 193.05
193. 06 19306 MGH PEDIATRIC CTR	0	0		0 8, 563	0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	0 193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 8, 563	0 193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 51, 376	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 0	0 193. 11
193. 12 19312 OB/GYN	0	0		0 94, 189	0 193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0 193. 15
193.16 19316 MGH NEONATOLOGY	0	0		0 0	0 193.16
193.18 19318 MGH WOUND CARE	0	0		0 0	0 193. 18
194.0007963 HEART FAILURE CLINIC	0	0		0 0	0 194.00
194. 01 07950 MOW	0	92, 917		0 0	0 194.01
194.0207951 MENTAL HEALTH	0	151, 102		0 0	0 194.02
194. 03 07952 ADVERTI SI NG	0	0		0 0	0 194.03
194.04 07953 MGH WORK SOLUTIONS	0	0		0 34, 251	0 194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0	0 194.05
194.0807957 MGH SMMP BLDG	0	0		0 0	0 194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0	0 194.09
194.1007959 MGH 106 LYONS BLDG	0	0		0 0	0 194. 10
194. 11 07960 FAI RMOUNT	0	0		0 0	0 194. 11
194. 12 07961 GAS CI TY	0	0		0 0	0 194. 12
194. 13 07969 LYONS	0	0		0 0	0 194.13
194. 14 07964 WABASH	0	0		0 0	0 194.14
194. 15 07965 TOBACCO GRANT	0	0		0 0	0 194. 15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0		0 0	0 194.16
194. 17 07967 HRSA OPI OLD PLANNI NG	0	0		0 17, 125	0 194. 17
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	3, 276, 117	1, 330, 251	1, 520, 17	1 856, 264	5, 557, 978 202. 00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	MARION GENERA	AL HOSPITAL Provider CC	N: 15 0011	In Lieu of Form CM Period: Worksheet	
CUST	LEUCATION - GENERAL SERVICE CUSIS		Provider CC	N: 15-0011	From 07/01/2018 Part I	
					To 06/30/2019 Date/Time 11/25/2019	Prepared: 10:38 am
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost & Post			
			Stepdown			
			Adjustments			
		24.00	25.00	26.00		
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
6. 00 6. 01	00600 MAI NTENANCE & REPAI RS 00601 CAFETERI A					6.00
6. 02	00602 CAFETERI A					6. 02
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	17, 731, 170	0	17, 731, 1	70	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 293, 276	0	5, 293, 2		31.00
40.00	04000 SUBPROVI DER – I PF	0	О		0	40.00
41.00	04100 SUBPROVI DER – I RF	3, 701, 486	0	3, 701, 48		41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 1, 737, 011	0	1, 737, 0 [.]	0	42.00
43.00	ANCI LLARY SERVICE COST CENTERS	1,737,011	V	1,737,0	11	43.00
50.00	05000 OPERATING ROOM	18, 353, 493	0	18, 353, 49	93	50.00
51.00	05100 RECOVERY ROOM	0	0	0 000 0	0	51.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	8, 923, 268 1, 617, 573	0	8, 923, 20 1, 617, 5		54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	909, 968	0	909, 90		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 920, 214	О	2, 920, 2		59.00
60.00	06000 LABORATORY	11, 568, 725	0	11, 568, 7		60.00
60. 01 60. 02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	2, 269, 621 0	0	2, 269, 6	0	60.01
65.00	06500 RESPI RATORY THERAPY	3, 672, 833	0	3, 672, 8	•	65.00
66.00	06600 PHYSI CAL THERAPY	3, 206, 668	о	3, 206, 6		66.00
69.00 69.01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	2, 390, 936 507, 865	0	2, 390, 9		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	507,885	0	507, 80	0	69.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ō		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 041, 052	0	15, 041, 0	52	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	1, 413, 078	0	1, 413, 0	70	90.00
	09100 EMERGENCY	11, 259, 030	0	11, 259, 0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,,	Ō			92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	2, 302, 505	0	2, 302, 50		95.00
95.00	SPECIAL PURPOSE COST CENTERS	2, 302, 303	U	2, 302, 50	05	95.00
	11300 INTEREST EXPENSE					113.00
118.00		114, 819, 772	0	114, 819, 7	72	118.00
190.00	NONREIMBURSABLE COST CENTERS	194, 145	0	194, 14	45	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1,1,1,	0	192.00
192.02	19202 VISITOR MEALS	63, 763	0	63, 7		192.02
	19203 GREAT BEGI NNI NGS/MATERNAL	163, 431	0	163, 43		192.03
	19204 LI FELI NE 19205 OWNED PROPERTI ES	-109, 424 278, 849	0	-109, 42 278, 84		192.04 192.05
	19206 UROLOGY	1, 938, 207	o	1, 938, 20		192.06
192.08	19211 PARI SH NURSI NG	78, 289	0	78, 28		192.08
	19212 BI OTERRORI SM GRANT	0	0		0	192.09
	19214 BREAST PUMPS 19208 MGH EMERGENCY PHYSICIANS	0	0		0	192.10 192.11
	19209 LUNG CENTER	1, 054, 433	0	1, 054, 43	33	192.12
192.13	19213 MGH EXPRESS	1, 380, 410	0	1, 380, 4	10	192.13
	19210 MGH PHYS PRACT MGMT	2, 427, 028	0	2, 427, 02		192.14
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	2, 933, 870 2, 114, 060	0	2, 933, 8 2, 114, 0		192.15 192.16
	19217 MGH MGH MED ONC 19217 MGH FMC SOUTH	4, 311, 002	0	2, 114, 00 4, 311, 00		192.17
	19218 MGH FAI RM MED ASSOC	527, 462	0	527, 40		192.18
1/2.10		1, 194, 744	0	1, 194, 74	4.4	192.19
192.19	19219 MGH FMC MARION		0	1, 171, 7		
192. 19 193. 00	19219 MGH FMC MARION 19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD	1, 194, 744 0 1, 923, 303	0	1, 923, 30	0	193. 00 193. 01

Health Financial Systems	MARION GENER	AL HOSPITAL		I	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01 To 06/30	Worksheet B 1/2018 Part I D/2019 Date/Time Prepared: 11/25/2019 10:38 am
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
193. 03 19303 MGH HOSPI TALI STS	5, 946, 686	0	5, 946, 6	686	193.03
193.04 19304 MGH MAR FAM PRACT	4, 534, 902	0	4, 534, 9	902	193.04
193.05 19305 MGH FMC SWAYZEE	370, 987	0	370, 9	987	193.05
193. 06 19306 MGH PEDIATRIC CTR	1, 473, 817	0	1, 473, 8	317	193.06
193.07 19307 MGH SPECIALTY PHYS	443, 744	0	443, 7	744	193.07
193.08 19308 MGH FMC CONVERSE	469, 985	0	469, 9	985	193.08
193.09 19309 MGH UPLAND HEALTH	2, 609, 347	0	2, 609, 3	347	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0	193.11
193. 12 19312 OB/GYN	4, 233, 199	0	4, 233, 1	99	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	193.15
193.16 19316 MGH NEONATOLOGY	770, 338	0	770, 3	338	193.16
193.18 19318 MGH WOUND CARE	33, 480	0	33, 4	180	193. 18
194.0007963 HEART FAILURE CLINIC	76, 377	0	76, 3	377	194.00
194. 01 07950 MOW	92, 917	0	92, 9	917	194. 01
194.0207951 MENTAL HEALTH	151, 102	0	151, 1	02	194.02
194. 03 07952 ADVERTI SI NG	402, 070	0	402, 0	070	194.03
194.0407953 MGH WORK SOLUTIONS	1, 368, 864	0	1, 368, 8	364	194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	240, 834	0	240, 8	334	194.05
194.0807957 MGH SMMP BLDG	0	0		0	194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0	194.09
194.1007959 MGH 106 LYONS BLDG	7, 625	0	7,6	525	194.10
194. 11 07960 FAI RMOUNT	0	0		0	194. 11
194. 12 07961 GAS CI TY	0	0		0	194.12
194. 13 07969 LYONS	0	0		0	194.13
194. 14 07964 WABASH	0	0		0	194.14
194. 15 07965 TOBACCO GRANT	98, 980	0	98, 9	980	194. 15
194. 16 07966 HRSA NETWORK DEV PLANNING	108, 583	0	108, 5	583	194.16
194. 17 07967 HRSA OPI OLD PLANNI NG	124, 726	0	124, 7	26	194. 17
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 through 201)	160, 048, 867	0	160, 048, 8	367	202.00

	Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 07/01/2018	Worksheet B Part II	
			1	T	06/30/2019	Date/Time Pre 11/25/2019 10	pared: :38 am
			CAPI TAL RELATED COSTS				
	Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
		Assigned New Capital	FLXT		BENEFI TS DEPARTMENT	E & GENERAL	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				447.000		1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				467, 893 56, 964	2, 084, 858	4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	C	0	0	0	0	6.00
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A	C	163, 071	163, 071	0	23, 167	6. 01 6. 02
7.02	00700 OPERATION OF PLANT		3, 291, 499	3, 291, 499	4, 766	-	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C	70, 943	70, 943	0		8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY		109, 453 224, 680		0	40, 323	9.00 10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	C	23, 368	23, 368	6, 230	18, 732	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY		,		955 19, 559		14.00 15.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1		1	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			1, 450, 347 336, 415	45, 124 14, 148		30.00 31.00
40.00	04000 SUBPROVI DER – I PF	C		0	0	0	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER		021/011	321, 811	7, 692	35, 955	41.00 42.00
	04300 NURSERY		-	0	6, 965	-	
50.00	ANCILLARY SERVICE COST CENTERS	C	1, 156, 739	1, 156, 739	0	199, 013	50.00
51.00	05100 RECOVERY ROOM			1, 150, 739	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0,1,020	694, 520	17, 191	96, 155	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		50, 529 59, 897	50, 529 59, 897	3, 698 1, 845		57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	169, 215	169, 215	4, 438	32, 241	59.00
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY		439, 690	439, 690	15, 614 7, 275	136, 946 29, 365	60.00 60.01
60.02	06002 RADIATION ONCOLOGY		0	0	0	0	60.02
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0		149, 574 29, 579	8, 965		65.00 66.00
69.00	06900 ELECTROCARDI OLOGY		29, 579 267, 051	267, 051	12, 939 6, 037	39, 901 22, 634	
	06901 CARDI AC REHAB	C	43, 546		1, 189		
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			0	0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0	0	0	123, 448	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	C	95, 083	95, 083	1, 963	15, 182	90.00
	09100 EMERGENCY	C		371, 702	52, 424		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	c c	o	0	0	0	92.00 92.01
	OTHER REIMBURSABLE COST CENTERS					1	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	C	139, 334	139, 334	7, 501	24, 356	95.00
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	C	12, 336, 914	12, 336, 914	303, 490	1, 508, 514	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	44, 620	44, 620	205		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS			0	0		192.00 192.02
192.03	19203 GREAT BEGI NNI NGS/MATERNAL	C	0	0	715	2, 039	192.03
	19204 LI FELI NE 19205 OWNED PROPERTI ES	0	0	0	0		192. 04 192. 05
	19206 UROLOGY			0	6, 662		
	19211 PARI SH NURSI NG	C	0	0	222		192.08
	19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS			0	0		192. 09 192. 10
192.11	19208 MGH EMERGENCY PHYSICIANS	C	0	0	0	0	192.11
	19209 LUNG CENTER 19213 MGH EXPRESS			0	2, 721 7, 059		192.12 192.13
192.14	19210 MGH PHYS PRACT MGMT	c	0	0	6, 918	30, 449	192.14
	19215 MGH MARION SURGEONS	0	0	0	13,052	37, 350	
	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH		0	0	9, 989 17, 039		
192.18	19218 MGH FAIRM MED ASSOC	C	0	0	1, 987	6, 866	192.18
	19219 MGH FMC MARION 19300 NONPALD WORKERS			0	4, 888 0		192. 19 193. 00
	19301 MGH FMC NORTHWOOD	C	0	0	8, 204		193.01

Health Financial Systems	MARION GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0011		riod: om 07/01/2018	Worksheet B Part II	pared:
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal		EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI V E & GENERAL	
	0	1.00	2A		4.00	5.00	
193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH HOSPITALISTS 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE	0 0 0 0	0 0 0 0		0 0 0 0	4, 598 17, 815 18, 258 1, 347	77, 412 58, 578 4, 606	193.05
193.06 19306 MGH PEDIATRIC CTR 193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH		0 0 0 0		0 0 0 0	5, 420 1, 933 1, 653 9, 941	5, 704 6, 006	193.06 193.07 193.08 193.09
193.10 193.11 193.11 193.12 193.12 193.12 193.15 19315 MGH RIVER VIEW BLDG		0 0 0		0 0 0	0 0 15, 745	0 53, 880	193. 10 193. 11 193. 12 193. 15
193. 16 19316 MGH NEONATOLOGY 193. 18 19318 MGH WOUND CARE 194. 00 07963 HEART FAILURE CLINIC 194. 01 07950 MOW		0		0 0 0	0 158 278 0	10, 028 436 994	193. 16 193. 18 194. 00 194. 01
194. 02 07951 MENTAL HEALTH 194. 03 07952 ADVERTI SI NG 194. 04 07953 MGH WORK SOLUTI ONS		0		00000	0 1, 232 4, 626	0 5, 133 17, 372	194. 02 194. 03 194. 04
194. 05 07954 MGH TAYLOR UNIVERSITY 194. 08 07957 MGH SMMP BLDG 194. 09 07958 MGH AMBUCARE BLDG 194. 10 07959 MGH 106 LYONS BLDG		0		00000	1, 088 0 0 0	0 0 99	194.05 194.08 194.09 194.10
194. 11 07960 FAI RMOUNT 194. 12 07961 GAS CI TY 194. 13 07969 LYONS 194. 14 07964 WABASH		0 0 0 0		0 0 0 0	0 0 0 0	0	194. 11 194. 12 194. 13 194. 14
194. 15 07965 TOBACCO GRANT 194. 16 07966 HRSA NETWORK DEV PLANNING 194. 17 07967 HRSA OPIOID PLANNING 200. 00 Cross Foot Adjustments	0 0 0	0 0 0		0 0 0 0	382 188 80	1, 395	194. 15 194. 16 194. 17 200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	0 12, 381, 534	12, 381, 5	0 34	0 467, 893		201. 00 202. 00

Health Financial Systems	MARI ON GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 07/01/2018	Worksheet B Part II	
				06/30/2019	Date/Time Pre 11/25/2019 10	pared:
Cost Center Description	MAINTENANCE &	CAFETERIA	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS 6. 00	6. 01	6. 02	PLANT 7.00	LINEN SERVICE 8.00	
GENERAL SERVICE COST CENTERS	0.00	0.01	0.02	7.00	0.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATIVE & GENERAL						4.00 5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0					6.00
6. 01 00601 CAFETERI A	0	186, 238				6.01
6. 02 00602 CAFETERIA 7. 00 00700 OPERATION OF PLANT	0	179, 565 0	179, 565 4, 598			6.02 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	4, 370		115, 812	
9.00 00900 HOUSEKEEPI NG	0	0	C		0	
10. 00 01000 DI ETARY 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	3 2, 928	,	0	10.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	2, 920		1, 565	
15. 00 01500 PHARMACY	0	0	9, 586	55, 084	0	15.00
30.00 03000 ADULTS & PEDIATRICS	0	0	28, 296	775, 082	26,009	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	20, 290 8, 627		5, 929	
40. 00 04000 SUBPROVI DER – I PF	0	0	C	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	4, 330	171, 979	3, 348	
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0	4, 151	0	0	42.00 43.00
ANCILLARY SERVICE COST CENTERS		-1	.,	-		
50. 00 05000 OPERATING ROOM	0	0	25, 567		18, 074	
51. 00 05100 RECOVERY ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0 12, 378	-	0 9, 197	51.00 54.00
57. 00 05700 CT SCAN	0	Ō	2, 641		3, 894	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 282		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0	2, 904 11, 631		1, 300	59.00 60.00
60. 01 06001 0NC0L0GY	0	0	0		935	•
60. 02 06002 RADI ATI ON ONCOLOGY	0	0	C	0	0	60.02
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0	5, 037 3, 338		995 3, 191	65.00 66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	4, 636		857	69.00
69. 01 06901 CARDI AC REHAB	0	0	853		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	-	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	-	0	73.00
OUTPATIENT SERVICE COST CENTERS		-		1		
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	0	1, 250 18, 207		571 34, 479	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	10, 207	190, 042	34, 479	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0	0	6, 540	74, 462	4, 786	95.00
SPECIAL PURPOSE COST CENTERS		0	0, 540	74,402	4,780	95.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 11 NONREIMBURSABLE COST CENTERS	7) 0	179, 565	159, 778	3, 413, 046	115, 133	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	138	23, 846	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C		0	192.00
192. 02 19202 VI SI TOR MEALS	0	6, 673	0	0		192.02
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 192. 04 19204 LI FELI NE	0	0	0	0		192. 03 192. 04
192.05 19205 OWNED PROPERTIES	0	0	C	0		192.05
192.06 19206 UROLOGY	0	0	2, 531			192.06
192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT	0	0	204	0		192.08 192.09
192. 10 19214 BREAST PUMPS	0	0	0	0		192.10
192. 11 19208 MGH EMERGENCY PHYSI CLANS	0	0	C	0		192.11
192. 12 19209 LUNG CENTER 192. 13 19213 MGH EXPRESS	0	0	1, 117	0		192. 12 192. 13
192. 14 19210 MGH PHYS PRACT MGMT	0	0	6, 684	0		192.13
192.15 19215 MGH MARI ON SURGEONS	0	0	3, 184	0	0	192. 15
192.16 19216 MGH MGH MED ONC	0	0	0	0		192. 16 192. 17
192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAIRM MED ASSOC	0	0	0	0		192.17
192.19 19219 MGH FMC MARION	0	Ö	2, 200	0	0	192.19
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
193.01 19301 MGH FMC NORTHWOOD 193.02 19302 MGH FMC GAS CITY	0	0		0		193. 01 193. 02
193. 03 19303 MGH HOSPI TALI STS	Ő	0 0	C	o o	0	193.03
193. 04 19304 MGH MAR FAM PRACT	0	0	0	Ŭ,		193.04
193.05 19305 MGH FMC SWAYZEE	0	0	C	0	. 2	193.05

Health Financial Systems	MARI ON GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od:	Worksheet B	
				rom 07/01/2018 0 06/30/2019		norod.
				o 06/30/2019	11/25/2019 10	
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	
193.06 19306 MGH PEDIATRIC CTR	0	0	1, 911			193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	581	0		193.07
193.08 19308 MGH FMC CONVERSE	0	0	(0 0		193.08
193.09 19309 MGH UPLAND HEALTH	0	0	(0 0		193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	(0 0		193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0	(0 0		193. 11
193. 12 19312 OB/GYN	0	0	(0 0		193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	(0 0		193.15
193.16 19316 MGH NEONATOLOGY	0	0	(0 0		193.16
193.18 19318 MGH WOUND CARE	0	0	(0 0		193. 18
194.0007963 HEART FAILURE CLINIC	0	0	(0 0		194.00
194.0107950 MOW	0	0	(0 0		194.01
194.0207951 MENTAL HEALTH	0	0	(-		194.02
194. 03 07952 ADVERTI SI NG	0	0	811			194.03
194.0407953 MGH WORK SOLUTIONS	0	0	(0 0		194.04
194.0507954 MGH TAYLOR UNIVERSITY	0	0	(0 0		194.05
194.0807957 MGH SMMP BLDG	0	0	(0 0		194.08
194.0907958 MGH AMBUCARE BLDG	0	0	(0 0		194.09
194.1007959 MGH 106 LYONS BLDG	0	0	(0 0		194.10
194. 11 07960 FAI RMOUNT	0	0	(0 0		194.11
194. 12 07961 GAS CI TY	0	0	(0 0		194.12
194. 13 07969 LYONS	0	0	(0		194.13
194.14 07964 WABASH	0	0	(0		194.14
194. 15 07965 TOBACCO GRANT	0	0	228			194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0	147			194.16
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0	51	0	0	194.17
200.00 Cross Foot Adjustments					_	200.00
201.00 Negative Cost Centers	0	10/ 000	170 575			201.00
202.00 TOTAL (sum lines 118 through 201)	0	186, 238	179, 565	3, 436, 892	115, 812	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provide CRI 15-001	Heal th	Financial Systems	MARI ON GENERA	L HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10	
Line Line <thline< th=""> Line Line <thl< td=""><td>ALLOCA</td><td>TION OF CAPITAL RELATED COSTS</td><td></td><td>Provider CO</td><td></td><td></td><td></td><td></td></thl<></thline<>	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO					
Cost Center Description INISENCE PINS 0 DETAIL WIRESING 3 CENTER. 3 PURAME/* 1:00 00000 10.00 10.00 14.00 15.00 16.00 10.00 14.00 10.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Date/Time Pre</td> <td>pared:</td>							Date/Time Pre	pared:	
Unit N Support To N 1000 100000 100000 100000		Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL			
UNIDED UNIDED<									
1.00 DUION INCE CAP REL COST S-BLIGG & FIXT 1.00 0.00 DORON LATURE TERFET FIX TO THE ALL COST S-DEARTING TO THE ALL COST S-DEAR			9.00	10.00			15.00		
4.00 DOLDO FUEL OFFERENTISTO FRANTINAT 4.00 5.00 DOBDO MAN STRATTUR & REMARL 5.00 6.00 DOBDO MAN STRATTUR & REMARL 6.00 6.00 DOBDO MANTELENCE & REMARL 6.00 6.00 DODDO PERTION OF PLANT 8.00 7.00 DODDO MORSECEN (% 2.08 9.00 DODDO MORSECEN (% 1.18 9.00 DOLDO CHINEL SERVICES a SUPPLY 4.790 14.00 DIADO CHINEL SERVICES (COST CONTENTION 2.62 10.00 DIADO CHINEL SERVICES (COST CONTENTION 2.02 10.00 DIADO CHINEL SERVICES (COST CONTENTING 1.22 10.00 DIADO CHINEL SERVICES (COST CONTENTING 1.22 10.00 DIADO CHINEL SERVICES (COST CONTENTING 1.23 10.00 DIADO CHINEL SERVICES (COST CONTENTING 1.22 10.00 DIADO CHINEL SERVICES (COST CONTENTING <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>								1.00	
5.00 000000 ADMINISTRATUPE & GENERAL. 5.00 6.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00									
0.01 00000 CAPETERIA 0 0.0000 CAPETERIA 0 0 0.0000 CAPETERIA 0 0 0.0000 CAPETERIA 0 0 0.0000 CAPETERIA 0 0 0 0 0 0.0000 CAPETERIA 0									
0.00 DOBDIC OFFITERIA									
7.00 000000 CONDO 0 PEANT 00 P.00 000000 FULL 0000000 FULL 000000000000 FULL 00000000000000000000000000000000000									
9.00 0000 HUSENCEP NG 0000 HUSENCEP NG 0000 HIGH NG	7.00	00700 OPERATION OF PLANT							
10.00 010000 010000 010000 010000 0100000 0100000 01000000 010000000 010000000000000 0100000000000000000000000000000000000			209 240						
13.00 01300 URES ING ADDIM ISTRATION 0-98 0 44, 704 13.00<				359, 744					
15.00 DISOD PHARMACY 2,682 0 0 0 258,405 15.00 IMPATTER NUTH SERVICE COST CENTERS 44,451 219,653 115,677 5,572 0 30.00 10.00 C3100 ADLTS A PFD ATER CS 44,451 219,653 115,677 5,572 0 31.00 11.00 C3100 INTERS VIE CARE NUTT 12,262 36,637 4,779 5,572 0 41.00 0.0100 SUBPROVIER 100,770 32,597 0 14,164 8,358 0 42.00 0.0300 NURSERY 0 0 2,850 0 4,179 5,572 0 14,164 8,358 0 0,00 5,600 5,600 5,600 5,600 5,600 5,600 5,620 5,600 5,620 5,600 5,600 5,600 5,600 5,600 5,600 5,620 5,600 5,600 5,620 5,600 5,620 5,600 5,600 5,600 5,620 5,600 5,600 5,600 5,600 6,600 6,600 6,600 <td>13.00</td> <td>01300 NURSING ADMINISTRATION</td> <td>958</td> <td>0</td> <td></td> <td></td> <td></td> <td>13.00</td>	13.00	01300 NURSING ADMINISTRATION	958	0				13.00	
INPATIENT ENDINE SERVICE COST ENTERS							259 105		
31.00 03100 INTERSIVE CARE UNIT 12.262 36.337 4,779 5.572 0 10.00 41.00 04100 SUBPROVIDER - IPF 0 0 2.399 1,393 0 41.00 42.00 94200 UNRESUP 0 0 2.309 0 42.00 43.00 94300 UNRESUP 0 0 2.300 0 42.00 40.00 04300 UNRESUP 0 0 1.64 8.389 0 50.00 00.00 05100 EEXPERT PROM 28.357 0 0 1.79 54.00 01.00 05700 CT SCAH 0 0 0 0 57.00 55.02 95.00 66.00 95.00 66.	15.00		2,002	0	0	0	238, 405	15.00	
do. Co. accols subprison DEP - 1 PF i		03000 ADULTS & PEDI ATRI CS							
11.00 04100 SUBPROVIDER - I BF 10.730 32.591 2.390 1.393 0 42.00 42.00 04200 0300 NURSERV 0 0 2.300 0 42.00 43.00 0300 RUNERSY 0 0 2.300 0 42.00 43.00 05000 OPERATING ROME 26.57 0 14.164 8.358 0 0 51.00 50.00 05000 OPERATING ROME 13.220 0 0 0 51.00 55.00 50.00 05000 CARUAC CATHERENCE LIAGING (MRI) 0 0 0 0 55.00 55.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00									
13.00 Diagon Numeserv Diagon Numeserv <thdiagon numeserv<="" th=""> Diagon Numeserv</thdiagon>			-	-	-	-			
ANCI LLARY SERVICE COST CENTRES 0.00 05000 (PERATINE NOM 28, 357 0 14, 164 8, 358 0 50, 00 51, 00 05000 (PERATINE NOM 0 0 0 0 0 0 51, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 56, 00 56, 00 55, 00 56, 00 56, 00 55, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 56, 00 67, 00 66, 00 67, 00 67, 00 67, 00 67, 00 67, 00 67, 00 67, 00				-	-				
50.00 05000 (PEEATING ROOM 28, 357 0 14, 164 8, 358 0 50.00 51.00 05000 (PECAVERY ROOM 0 <td< td=""><td>43.00</td><td></td><td>0</td><td>0</td><td>2,300</td><td>0</td><td>0</td><td>43.00</td></td<>	43.00		0	0	2,300	0	0	43.00	
54. 00 65400 (CT SCAN 0 0 1.12,220 0 0 1.12,220 0 0 1.12,220 0 0 0 57.00	50.00	05000 OPERATING ROOM	28, 357	0	14, 164	8, 358	0	50.00	
57. 00 05700 CT SCAM 0 0 0 0 0 0 0 0 0 57. 00 58. 00 05800 CARDIAC CATHETERIZATION 3.832 0 1.609 5.572 0 99. 00 60. 00 6000 CARDIAC CATHETERIZATION 3.832 0 1.609 5.572 0 99. 00 60. 01 60. 00 72. 00 73			-			-			
58. 00 0 GSB00 MAGHETIC RESONANCE LIMAGING (MRI) 0 <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td>				-	-				
60.00 00000 (AB0RATORY 10.730 0 8.358 0 60.01 60.01 00001 (NOCLOCY 0 0 1.393 0 60.01 60.02 60000 (RSP) RATORY THERAPY 0 <th< td=""><td></td><td></td><td></td><td>-</td><td>0</td><td>-</td><td></td><td></td></th<>				-	0	-			
60. 01 0 6001 0 6001 0 6001 0 6000 0 71.000 0 69.01 71.000 0 69.01 72.00 72.0				-			0		
60. 02 660.02 AGO LADIA TI ON ONCOLOCY 0				-			-		
66.00 06600 06400 1.849 0 66.00 66.00 69.00 06490 1.849 0 1.849 0 0 69.00				-	0		-		
69:00 0oppol ElectrococARD OLOGY 5, 17.8 0 2,568 4, 179 0 69:00 73:00 73:00 73:00 73:00 73:00 73:00 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-					
69.01 0op01 CARDIA CRHAB 5,748 0 473 0 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0				-		-			
12. 00 072.00 IMPL Dev. CHARGED TO PATIENTS 0 0 0 0 258, 405 73. 00 00.00 000000 CLUS 3, 832 0 693 0 90. 00 00000 CLINIC 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 0 0 0 0 92. 00 92. 01 92. 01 92. 01 0 0 0 0 92. 00 92. 00 92. 01 93. 00 0 0 92. 01 92. 01 92. 01 93. 00 0 0 0 01. 00 01. 00	69.01	06901 CARDI AC REHAB		-		0	0	69.01	
73.00 O O O O 258,405 73.00 90.00 OUTPATIENT SERVICE COST CENTERS 0 693 0 09.00 0 09000 (LINC 3,832 0 693 0 0 00.00 90.00 91.00 09000 (LINC 45.985 4,972 10,071 5,572 0 92.00 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td></td> <td></td>				-		-			
90.00 000000 000000 000000000000000000000000000000000000				-					
91 00 091 00 EMR GENCY 45,985 4,972 10,071 5,572 0 91.00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.00 92.01 92.01 92.01 92.00 92.01 92.00 92.01 92.00 92.01 92.00 92.01 92.00 92.01 92.00 92.01 92.00 92.01 92.00 92.01 92.00 92.01								1	
92.00 09200 0DSERVATION BEDS (NON-DI STI NCT PART) 0 0 0 92.00 92.00 92.01 92.00 92.01 9				-		-		1	
OTHER REI MBURSABLE COST CENTERS 95.00 OPSOOL AMBULANCE SERVICES 1, 341 0 3, 623 1, 393 0 113.00 113.00 3, 62, 994 7, 3, 827 258, 405 113.00 100.00 0 <th c<="" td=""><td></td><td></td><td>43, 703</td><td>7, 772</td><td>10,071</td><td>5, 572</td><td>0</td><td></td></th>	<td></td> <td></td> <td>43, 703</td> <td>7, 772</td> <td>10,071</td> <td>5, 572</td> <td>0</td> <td></td>			43, 703	7, 772	10,071	5, 572	0	
95.00 9500 AMBULANCE SERVICES 1,341 0 3,623 1,393 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTERST EXPENSE 113.00 11300 FLINERST EXPENSE 113.00 11300 FLINEST EXPENSE 113.00 113.00 11300 FLINEST EXPENSE 113.00 11300 FLINEST EXPENSE 113.00 119.00 119.00	92.01		0	0	0	0	0	92.01	
SPECIAL PURPOSE COST CENTERS 113.00 <td>95 00</td> <td></td> <td>1 341</td> <td>0</td> <td>3 623</td> <td>1 393</td> <td>0</td> <td>95 00</td>	95 00		1 341	0	3 623	1 393	0	95 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 205, 204 293, 753 62, 994 73, 827 258, 405 118.00 NORRE IMBURSABLE COST CENTERS 0	70100				0,020	., ., .,	Ŭ	70100	
NONREL MBURSABLE COST CENTERS 190.00 0 IFT, FLOWER, COFFEE SHOP & CANTEEN 383 0 0 0 0 190.00 192.00 19203 GIFT, FLOWER, COFFEE SHOP & CANTEEN 383 0 192.02 192.02 192.03 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 0 0 192.03 192.05 192.05 0 0 0 192.05 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.02 0 0 0 192.06 192.02 0 192.02 0 192.02 192.02 192.02 192.02 192.02 192.02 192.06			205 204	202 752	(2,004	70 007	250 405		
1900.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 383 0 0 0 0 190.00 192.02 19202 VISICI ANS' PRI VATE OFFICES 0	118.00		205, 204	293, 753	02, 994	/3,827	258, 405	118.00	
192. 02 192.02 VI SI TOR MEALS 0 0 0 192. 02 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 289 0 0 192. 03 192. 04 19204 LI FELI NE 0 0 0 0 192. 03 192. 05 19205 OWNED PROPERTI ES 766 0 0 192. 05 192. 06 19206 UROLOGY 0 0 0 192. 06 192. 08 19211 PARI SH NURSI NG 383 0 0 0 192. 08 192. 10 19214 BREAST PUMPS 0 0 0 0 192. 01 192. 10 19214 BREAST PUMPS 0 0 0 0 192. 10 192. 11 19209 LUNG CENTER 0 0 0 0 192. 12 192. 13 19213 MGH EXPRESS 0 0 0 192. 13 192. 13 192. 14 19215 MGH ING NURGEONS 0 0 0 192. 16 192. 15 19215<		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 1			-			
192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 289 0 0 192.03 192.04 LI FELI NE 0 0 0 0 0 192.04 192.05 19205 OWNED PROPERTIES 766 0 0 0 192.06 192.06 19205 UROLOGY 0 0 0 192.06 192.06 192.08 19211 PARI SH NURSI NG 383 0 0 0 192.08 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.09 192.10 19214 BREAST PUMPS 0 0 0 0 192.10 192.11 19208 MGH EMERGENCY PHYSI CI ANS 0 0 0 192.11 192.12 19209 LUNG CENTER 0 0 0 192.12 192.13 MGH EXPRESS 0 0 1,421 0 192.15 192.14 19210 MGH MARI ON SURGEONS 0 0 0 192.15 192.15 MGH MARI ON S			1 1			0			
192.05 19205 OWNED PROPERTIES 766 0 0 0 192.05 192.06 19206 URDLOGY 0 0 0 192.06 192.08 19211 PARISH NURSING 383 0 0 0 192.09 192.09 19212 BIOTERRORISM GRANT 0 0 0 192.09 192.10 19214 BREAST PUMPS 0 0 0 0 192.01 192.12 BIOTERRORISM GRANT 0 0 0 0 192.02 192.12 BREAST PUMPS 0 0 0 0 192.10 192.13 19213 MGH EMERGENCY PHYSI CLANS 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 1,421 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 1,533 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 0 192.15 192.16 19217 MGH FARK MED ASSOC <td< td=""><td></td><td></td><td></td><td>-</td><td></td><td>0</td><td></td><td></td></td<>				-		0			
192.0619206UROLOGY04,1790192.06192.0819211PARI SH NURSI NG383000192.08192.0919212BI OTERRORI SM GRANT0000192.09192.1019214BREAST PUMPS0000192.10192.1119208MGH EMERGENCY PHYSI CI ANS0000192.11192.1219209LUNG CENTER0000192.12192.1319213MGH EXPRESS0000192.13192.1419210MGH MARI ON SURGEONS0000192.15192.1519216MGH MARI ON SURGEONS0000192.16192.1619216MGH MED ONC0000192.17192.1819218MGH FAI RM MED ASSOC0000192.18192.1919219MGH FAI RM MED ASSOC0000192.19193.0119301MGH FMC NORTHWOOD0000193.01193.0219303MGH FMC NORTHWOOD0000193.03193.0319303MGH FMC SC CITY00000193.03193.0319303MGH HOSPITALI STS00000193.03				0		0			
192.08 19211 PARI SH NURSI NG 383 0 0 0 192.08 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.09 192.10 19214 BREAST PUMPS 0 0 0 0 192.09 192.11 19208 MGH EMERGENCY PHYSI CI ANS 0 0 0 0 192.10 192.12 19209 LUNG CENTER 0 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 0 0 192.13 192.15 19215 MGH MARI ON SURGEONS 0 0 0 0 192.15 192.16 19216 MGH MGH MED ONC 0 0 0 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 192.15 192.19 19219 MGH FMC MARI ON 0 0 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 192.17 192.19 19219 <td></td> <td></td> <td>1 1</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>			1 1	0	0				
192.1019214BREAST PUMPS000192.10192.1119208MGH EMERGENCY PHYSI CLANS0000192.11192.1219209LUNG CENTER0000192.12192.1319213MGH EXPRESS001,42100192.13192.1419210MGH PHYS PRACT MGMT1,533000192.15192.1519215MGH MARI ON SURGEONS000192.16192.16192.1719217MGH FMC SOUTH0000192.17192.1819218MGH FAI RM MED ASSOC0000192.18192.1919300NONPALD WORKERS0000193.01193.0119301MGH FMC NARI ON000193.00193.01193.0319303MGH HOSPITALI STS0000193.03				0	0				
192.11 19208 MGH EMERGENCY PHYSICIANS 0 0 0 192.11 192.12 19209 LUNG CENTER 0 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 1,421 0 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 1,533 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.16 192.16 19216 MGH MEL ONSC 0 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 193.01 193.01 193.02 193.02 193.03 193.03				0	0	0			
192.12 19209 LUNG CENTER 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 1,421 0 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 1,533 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.15 192.16 19216 MGH MED ONC 0 0 0 192.16 192.17 MGH FMC SOUTH 0 0 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 192.17 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 193.01 19300 MGH FMC NORTHWOOD 0 0 0 193.02 193.03 193.03 193.03 193.03 193.03 193.03 193.03			0	-	-	0			
192.1419210MGHPHYSPRACTMGMT1,533000192.14192.1519215MGHMARI ONSURGEONS0005,5720192.15192.1619216MGHMGHMEDONC0000192.16192.1719217MGHFMCSOUTH0000192.17192.1819218MGHFAI RMMEDASSOC000192.18192.1919219MGHFMCMARI ON000192.19193.0019300NONPAI DWORKERS000193.01193.0119301MGHFMCASC CITY000193.02193.0319303MGHHOSPI TALI STS0000193.03			0	0		0	0	192.12	
192.15MGH MARI ON SURGEONS005,5720192.15192.1619216MGH MED ONC0000192.16192.1719217MGH FMC SOUTH0000192.17192.1819218MGH FAI RM MED ASSOC0000192.18192.1919219MGH FMC MARI ON0000192.19193.0019300NONPAI D WORKERS0000193.00193.0119301MGH FMC NORTHWOOD000193.01193.0219302MGH FMC GAS CITY0000193.02193.0319303MGH HOSPITALISTS0000193.03				0	1, 421	0			
192.16 19216 MGH MED ONC 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 5,572 0 192.17 192.18 19218 MGH FALRM MED ASSOC 0 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 193.01 193.01 19301 MGH FMC NORTHWOOD 0 0 193.01 193.02 193.02 19302 MGH FMC GAS CITY 0 0 0 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03				0	0	0 5. 572			
192.18MGH FAI RM MED ASSOC000192.18192.1919219MGH FMC MARI ON0002,7860192.19193.0019300NONPAI D WORKERS00000193.00193.0119301MGH FMC NORTHWOOD0000193.01193.0219302MGH FMC GAS CITY0002,7860193.02193.0319303MGH HOSPITALISTS00000193.03	192.16	19216 MGH MGH MED ONC	0	0	0	0	0	192.16	
192.19MGH FMC MARI ON002,7860192.19193.0019300NONPAI D WORKERS0000193.00193.0119301MGH FMC NORTHWOOD0000193.01193.0219302MGH FMC GAS CITY0002,7860193.02193.0319303MGH HOSPITALISTS00000193.03			0	-	0	5, 572			
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 0 1,393 0 193.01 193.02 19302 MGH FMC GAS CITY 0 0 0 2,786 0 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03				0	0	0 2. 786			
193.02 MGH FMC GAS CITY 0 0 2,786 0 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03	193.00	19300 NONPAI D WORKERS	0	-	0	0	0	193.00	
193. 03 19303 MGH HOSPITALISTS 0 0 0 0 193. 03			0	0	0				
			0	0	0				
			0	0	0	5, 572			

Health Financial Systems	MARI ON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Prepared: 11/25/2019 10:38 am
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI N	CENTRAL D SERVI CES & SUPPLY	PHARMACY
	9.00	10.00	13.00	14.00	15.00
193.05 19305 MGH FMC SWAYZEE	0	0		0 2, 786	0 193.05
193. 06 19306 MGH PEDIATRIC CTR	0	0		0 1, 393	0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	0 193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 1, 393	0 193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 8, 358	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 0	0 193. 11
193. 12 19312 OB/GYN	0	0		0 15, 323	0 193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0 193. 15
193.16 19316 MGH NEONATOLOGY	0	0		0 0	0 193. 16
193.18 19318 MGH WOUND CARE	0	0		0 0	0 193. 18
194.0007963 HEART FAILURE CLINIC	0	0		0 0	0 194.00
194. 01 07950 MOW	0	25, 128		0 0	0 194.01
194.0207951 MENTAL HEALTH	0	40, 863		0 0	0 194.02
194. 03 07952 ADVERTI SI NG	0	0		0 0	0 194.03
194.04 07953 MGH WORK SOLUTIONS	0	0		0 5, 572	0 194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0	0 194.05
194.0807957 MGH SMMP BLDG	0	0		0 0	0 194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0	0 194.09
194. 10 07959 MGH 106 LYONS BLDG	0	0		0 0	0 194. 10
194. 11 07960 FAI RMOUNT	0	0		0 0	0 194. 11
194. 12 07961 GAS CI TY	0	0		0 0	0 194. 12
194. 13 07969 LYONS	0	0		0 0	0 194. 13
194. 14 07964 WABASH	0	0		0 0	0 194. 14
194. 15 07965 TOBACCO GRANT	0	0		0 0	0 194, 15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0		0 0	0 194, 16
194. 17 07967 HRSA OPI OLD PLANNI NG	0	0		0 2,786	0 194. 17
200.00 Cross Foot Adjustments		-		,	200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	208, 269	359, 744	64, 70	4 139, 298	258, 405 202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	MARION GENERA	AL HOSPITAL Provider CCI	N: 15 0011	In Lieu of Form CM Period: Worksheet E	
ALLUUF	ITON OF CAPITAL RELATED COSTS		Provider CCI	1: 15-0011	From 07/01/2018 Part II	
					To 06/30/2019 Date/Time F 11/25/2019	Prepared: 10:38 am
	Cost Center Description	Subtotal	Intern &	Total		
			Residents			
			Cost & Post Stepdown			
			Adjustments			
		24.00	25.00	26.00		
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
6.00	00600 MAINTENANCE & REPAIRS					6.00
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A					6.0
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
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 700 000		0 700 00		
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 792, 889 657, 940	0	2, 792, 88 657, 94		30.00
	04000 SUBPROVIDER - IPF	037, 940	0	007,94	0	40.00
41.00	04100 SUBPROVI DER – I RF	592, 228	0	592, 22	28	41.00
42.00	04200 SUBPROVI DER	0	0		0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	34, 808	0	34, 80	J8	43.00
50.00	05000 OPERATING ROOM	2,068,446	0	2,068,44	16	50.00
51.00	05100 RECOVERY ROOM	0	0		0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 217, 999	0	1, 217, 99		54.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 137 105, 447	0	107, 13 105, 44		57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	311, 541	0	311, 54		59.00
60.00	06000 LABORATORY	857, 947	0	857, 94	17	60.00
60.01	06001 ONCOLOGY	38, 968	0	38, 96		60.0
60.02 65.00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	0 304, 466	0	304, 46	0	60.02 65.00
66.00	06600 PHYSI CAL THERAPY	106, 604	0	106, 60		66.00
	06900 ELECTROCARDI OLOGY	455, 850	0	455, 85		69.00
69.01	06901 CARDI AC REHAB	79, 339	0	79, 33		69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	381, 853	0	381, 85	-	73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00 91.00	09000 CLINIC 09100 EMERGENCY	169, 387	0	169, 38		90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	862, 760	0	862,76	50	91.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	92.0
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	263, 336	0	263, 33	36	95.00
113.00	11300 I NTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	11, 408, 945	0	11, 408, 94	15	118.00
100.00	NONREI MBURSABLE COST CENTERS	70 (7)		70 / 7	7	100.00
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES	70, 676 0	0 O	70, 67	0	190.00 192.00
	19202 VI SI TOR MEALS	6, 673	0	6,67		192.02
192.03	19203 GREAT BEGI NNI NGS/MATERNAL	3, 043	0	3, 04		192.03
		0	0	4 00	0	192.04
	19205 OWNED PROPERTIES 19206 UROLOGY	4, 239 37, 954	0	4, 23 37, 95		192.05 192.06
	19211 PARI SH NURSI NG	1, 724	0	1, 72		192.08
192.09	19212 BI OTERRORI SM GRANT	0	О		0	192.09
	19214 BREAST PUMPS	0	0		0	192.10
	19208 MGH EMERGENCY PHYSICIANS 19209 LUNG CENTER	0 17, 425	0	17, 42	25	192. 1 192. 1
	19213 MGH EXPRESS	26, 160	0	26, 16		192.13
192.14	19210 MGH PHYS PRACT MGMT	45, 584	0	45, 58	34	192. 1
	19215 MGH MARI ON SURGEONS	59, 158	0	59, 15		192.1
	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	37, 509 78, 313	0	37, 50 78, 31		192. 10 192. 1
	19218 MGH FAIRM MED ASSOC	8, 860	0	8,86		192.18
		0,0001	01			
192. 18 192. 19	19219 MGH FMC MARION	24, 930	0	24, 93	30	192.19
192. 18 192. 19 193. 00			0	24, 93	30 0	

Health Financial Systems	MARION GENER	AL HOSPITAL		In Li	eu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 07/01/201 To 06/30/201	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
193. 03 19303 MGH HOSPI TALI STS	95, 227	0	95, 2	27	193.03
193.04 19304 MGH MAR FAM PRACT	82, 550	0	82, 5	50	193.04
193.05 19305 MGH FMC SWAYZEE	8, 741	0	8, 7	41	193.05
193. 06 19306 MGH PEDIATRIC CTR	27, 567	0	27, 5	67	193.06
193.07 19307 MGH SPECIALTY PHYS	8, 218	0	8, 2	18	193.07
193.08 19308 MGH FMC CONVERSE	9, 056	0	9, 0	56	193.08
193.09 19309 MGH UPLAND HEALTH	51, 845	0	51,8	45	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0	193. 11
193. 12 19312 OB/GYN	84, 948	0	84, 9	48	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	193.15
193.16 19316 MGH NEONATOLOGY	10, 028	0	10, 0	28	193.16
193.18 19318 MGH WOUND CARE	594	0	5	94	193. 18
194.0007963 HEART FAILURE CLINIC	1, 272	0	1, 2	.72	194.00
194. 01 07950 MOW	25, 128	0	25, 1	28	194.01
194.0207951 MENTAL HEALTH	40, 863	0	40, 8	63	194.02
194. 03 07952 ADVERTI SI NG	7, 176	0	7, 1	76	194.03
194.04 07953 MGH WORK SOLUTIONS	27, 587	0	27, 5	87	194.04
194. 05 07954 MGH TAYLOR UNIVERSITY	4, 223	0	4,2	23	194.05
194.0807957 MGH SMMP BLDG	0	0		0	194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0	194.09
194.1007959 MGH 106 LYONS BLDG	99	0		99	194.10
194. 11 07960 FAI RMOUNT	0	0		0	194.11
194. 12 07961 GAS CI TY	0	0		0	194.12
194. 13 07969 LYONS	0	0		0	194.13
194. 14 07964 WABASH	0	0		0	194.14
194.1507965 TOBACCO GRANT	1, 870	0	1,8	70	194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	1, 730	0	1, 7	30	194.16
194. 17 07967 HRSA OPIOLD PLANNING	4, 311	0	4, 3	11	194.17
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 through 201)	12, 381, 534	0	12, 381, 5	34	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MARION GENERA	L HOSPITAL Provider C		eriod:	u of Form CMS-: Worksheet B-1	
					rom 07/01/2018 o 06/30/2019	Date/Time Pre	
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SOUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	AI NTENANCE & REPAI RS (SQUARE FEET)	: <u>38 am</u>
		1.00	4.00	5A	5.00	6.00	
1.00 4.00 5.00 6.00 6.01 6.02 7.00 8.00	GENERAL SERVICE COST CENTERS 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	368, 779 13, 936 60, 400 0 4, 857 0 98, 036 2, 113	65, 159, 453 7, 934, 447 0 0 663, 677 0	-23, 667, 711 0 0 0 0 0 0	0	294, 443 4, 857 0 98, 036 2, 113	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	00900 HOUSEKEEPI NG 01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 260 6, 692 696 2, 383 3, 070 43, 198	0 1, 133 867, 507 133, 012 2, 723, 670 6, 283, 831		2, 639, 784 780, 127 1, 226, 339 538, 670 4, 479, 281	3, 260 6, 692 696 2, 383 3, 070 43, 198	9.00 10.00 13.00 14.00 15.00
31.00 40.00 41.00 42.00 43.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	10, 020 0 9, 585 0 0	1, 970, 151 0 1, 071, 167 0 969, 937		3, 540, 864 0 2, 353, 848 0 1, 400, 476	10, 020 0 9, 585 0 0	31.00 40.00 41.00 42.00 43.00
51.00 54.00 57.00 58.00 59.00 60.00 60.01	05000 OPERATING ROOM 05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 ONCOLOGY 06002 RADIATION ONCOLOGY 06500 RESPIRATORY THERAPY	34, 453 0 20, 686 1, 505 1, 784 5, 040 13, 096 0 0	0 2, 393, 999 514, 994 256, 948 617, 964 2, 174, 367 1, 013, 129 0		0 6, 294, 935 1, 268, 132 681, 769 2, 110, 727 8, 965, 367 1, 922, 453 0	34, 453 0 20, 686 1, 505 1, 784 5, 040 13, 096 0 0	51.00 54.00 57.00 58.00 59.00 60.00 60.01 60.02
66.00 69.00 69.01 71.00 72.00 73.00	06500 RESPIRATOR THERAFT 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 00TPATI ENT SERVICE COST CENTERS 09000 CLINIC	4, 455 881 7, 954 1, 297 0 0 0 0	1, 248, 429 1, 801, 796 840, 729 165, 633 0 0 0 0 273, 379			4, 455 881 7, 954 1, 297 0 0 0 2, 832	66.00 69.00 69.01 71.00 72.00 73.00
91. 00 92. 00 92. 01	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	11, 071	7, 300, 383		7, 902, 180	11, 071 0	91.00 92.00 92.01
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	4, 150	<u>1, 044, 519</u> 42, 264, 801			4, 150	113.00
192. 00 192. 02 192. 03	NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19202 VI SI TOR MEALS 19203 GREAT BEGI NNI NGS/MATERNAL	1, 329 0 0 0	28, 592 0 0 99, 627		97, 148 0 0 133, 486	0 0 0	190.00 192.00 192.02 192.03
192.05 192.06 192.08 192.09 192.10	19204 LI FELI NE 19205 OWNED PROPERTI ES 19206 UROLOGY 19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS 19208 MGH EMERGENCY PHYSI CLANS		0 0 927, 795 30, 904 0 0 0 0		0 227, 367 1, 609, 279 59, 920 0 0 0	0 0 0 0 0	192.04 192.05 192.06 192.08 192.09 192.10 192.11
192. 12 192. 13 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19	19209 LUNG CENTER 19209 LUNG CENTER 19213 MGH EXPRESS 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 NONPAI D WORKERS		378, 958 982, 964 963, 439 1, 817, 620 1, 390, 972 2, 372, 795 276, 738 680, 637		889, 518 1, 147, 221 1, 993, 393 2, 445, 196 1, 801, 650 3, 644, 595 449, 482 985, 678	0 0 0 0 0 0 0 0 0 0 0 0	192. 11 192. 12 192. 13 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENERA		CN 15 0011		eu of Form CMS-2	
CUST ALLUCATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2018	Worksheet B-1	
				To 06/30/2019	Date/Time Pre	
	0.0017.01				11/25/2019 10	:38 ar
	CAPI TAL					
Cost Center Description	RELATED COSTS NEW BLDG &	EMPLOYEE	Poconciliati	ADMI NI STRATI V	MAINTENANCE 8	
Cost center beschiption	FIXT	BENEFITS	n	E & GENERAL	REPAIRS	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
	FEET)	(GROSS		COST)	FEET)	
	,	SALARI ES)		,	,	
	1.00	4.00	5A	5.00	6.00	
193.01 19301 MGH FMC NORTHWOOD	0	1, 142, 494		0 1, 631, 785		193.0
193.02 19302 MGH FMC GAS CITY	0	640, 360		0 1,005,263		193.0
193. 03 19303 MGH HOSPITALISTS	0	2, 480, 815		0 5, 067, 902		193.0
193. 04 19304 MGH MAR FAM PRACT	0	2, 542, 538		0 3, 834, 880 0 301 560		193.0
193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDIATRIC CTR	0	187, 599		001,000		193. 0 193. 0
193. 07 19307 MGH SPECIALTY PHYS	0	754, 763 269, 150		0 1, 233, 128 0 373, 439		193.0
193. 08 19308 MGH FMC CONVERSE	0	230, 133		0 373, 439		193.0
193. 09 19309 MGH UPLAND HEALTH	0	1, 384, 389	1	0 2, 178, 682		193.0
193. 10 19310 MGH MGH WOMENS CTR	0	1, 304, 307	1	0 2,170,002		193.1
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0 0		193.1
193. 12 19312 OB/GYN	0	2, 192, 659	1	3, 527, 359		193.1
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0	193.1
193.16 19316 MGH NEONATOLOGY	0	0		0 656, 500		193.1
193.18 19318 MGH WOUND CARE	0	22, 067		0 28, 532		193.1
194.0007963 HEART FAILURE CLINIC	0	38, 741		0 65, 090		194.0
194. 01 07950 MOW	0	0		0 0		194.0
194.0207951 MENTAL HEALTH	0	0		0 0		194.0
194. 03 07952 ADVERTI SI NG	0	171, 534		0 336, 045		194.0
194. 04 07953 MGH WORK SOLUTIONS	0	644, 264		0 1, 137, 304		194.0
194. 05 07954 MGH TAYLOR UNIVERSITY 194. 08 07957 MGH SMMP BLDG	0	151, 504 0		0 205, 244		194.0
194.08 07957 MGH_SMMPBLDG 194.09 07958 MGH_AMBUCARE_BLDG	0	0		0 0		194.0 194.0
194. 10/07959 MGH 106 LYONS BLDG	0	0		0 6, 498		194.0
194. 11 07960 FAI RMOUNT	0	0		0 0,470		194.1
194. 12 07961 GAS CITY	0	0		0 0		194.1
194. 13 07969 LYONS	0	0		0 0		194.1
194. 14 07964 WABASH	0	0		0 0		194.1
194. 15 07965 TOBACCO GRANT	0	53, 256		0 82, 498	0	194.1
194.1607966 HRSA NETWORK DEV PLANNING	0	26, 246		0 91, 338	0	194.1
194. 17 07967 HRSA OPI OLD PLANNI NG	0	11, 099		0 91, 286	0	194.1
200.00 Cross Foot Adjustments						200. 0
201.00 Negative Cost Centers						201.0
202.00 Cost to be allocated (per Wkst. B, Part I)	12, 381, 534	19, 088, 470		23, 667, 711	0	202.0
203.00 Unit cost multiplier (Wkst. B, Part I)	33. 574401	0. 292950		0. 173402	0.000000	203.0
204.00 Cost to be allocated (per Wkst. B, Part II)		467, 893		2, 084, 858	0	204.0
205.00 Unit cost multiplier (Wkst. B, Part		0. 007181		0. 015275	0. 000000	205.0
206.00 NAHE adjustment amount to be allocated						206. 0
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207.0
Parts III and IV)						

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENERAL	L HOSPITAL Provider CO	°N: 15_0011 □	In Lieu Period:	u of Form CMS-2 Worksheet B-1	
COST ALLOCATION - STATISTICAL DASIS		Trovider co	F	rom 07/01/2018 o 06/30/2019	Date/Time Pre	pared:
Cost Center Description	CAFETERI A (MEALS SERVED)	CAFETERI A (HOURS WORKED)	OPERATI ON OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	11/25/2019 10 HOUSEKEEPI NG (HOURS OF SERVI CE)	: 38 am
	6. 01	6.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 6.01 00601 CAFETERI A 6.02 00602 CAFETERI A 6.03 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 PHARMACY INPATI ENT ROUTI NE SERVI CE COST CENTERS	230, 620 222, 357 0 0 0 0 0 0 0 0 0	1, 353, 564 34, 659 0 19 22, 075 7, 500 72, 263	191, 550 2, 113 3, 260 6, 692 696 2, 383	692, 615 0 0 0 0 9, 361	56, 524 832 260 1, 300 728	$\begin{array}{c} 1.00\\ 4.00\\ 5.00\\ 6.01\\ 6.02\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 13.00\\ 14.00\\ 15.00 \end{array}$
30. 00 03000 ADULTS & PEDI ATRI CS	0	213, 299	43, 198	155, 547	12, 064	30.00
31.00 03100 I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY	0 0 0 0	65, 027 0 32, 641 0 31, 289	C 9, 585 C	0 20, 023 0	3, 328 0 2, 912 0 0	31.00 40.00 41.00 42.00 43.00
ANCI LLARY SERVI CE COST CENTERS	0	192, 722	34, 453	108, 091	7,696	50.00
51.00 05100 RECOVERY ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC 57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 0 0	93, 305 19, 907 9, 662	0 20, 686 1, 505	0 55, 005 23, 291	7, 070 0 3, 588 0 0	50.00 51.00 54.00 57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	21, 893			1, 040	59.00
60. 00 06000 LABORATORY	0	87, 678			2, 912	60.00
60. 01 06001 0NC0L0GY 60. 02 06002 RADI ATI ON ONC0L0GY	0	0			0	60.01 60.02
65. 00 06500 RESPI RATORY THERAPY	0	37, 970	4,455	5, 949	2, 184	65.00
66.00 06600 PHYSI CAL THERAPY	0	25, 165			0	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	34, 944 6, 433			1, 404 1, 560	69.00 69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0, 100			0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0	C	0 0	0	73.00
90. 00 09000 CLINIC	0	9, 425	2,832	3, 417	1,040	90.00
91.00 09100 EMERGENCY	0	137, 242	11, 071	206, 187	12, 480	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		<u> </u>	0	92.01
95. 00 09500 AMBULANCE SERVICES	0	49, 298	4, 150	28, 620	364	95.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	222, 357	1, 204, 416	190, 221	688, 546	55, 692	118.00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 040	1, 329			190.00 192.00
192. 02 19202 VI SI TOR MEALS	8, 263	0		0		192.00
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	0	0	C	0	0	192.03
192. 04 19204 LI FELI NE	0	0	C	0		192.04
192. 05 19205 OWNED PROPERTIES 192. 06 19206 UROLOGY	0	0 19, 081			208	192.05 192.06
192. 08 19211 PARI SH NURSI NG	0	1, 539		0		192.08
192. 09 19212 BI OTERRORI SM GRANT	0	0	C	0		192.09
192. 10 19214 BREAST PUMPS 192. 11 19208 MGH EMERGENCY PHYSI CLANS	0	0				192. 10 192. 11
192. 12 19209 LUNG CENTER	0	8, 418		0		192.12
192.13 19213 MGH EXPRESS	О	0	C	934	0	192. 13
192.14 19210 MGH PHYS PRACT MGMT 192.15 19215 MGH MARI ON SURGEONS	0	50, 381 23, 998				192. 14 192. 15
192. 16 19215 MGH MARION SURGEONS 192. 16 19216 MGH MGH MED ONC	0	∠3, 998 0				192.15
192.17 19217 MGH FMC SOUTH	Ō	0	0	188	0	192. 17
192. 18 19218 MGH FAI RM MED ASSOC	0	0		42		192.18
192. 19 19219 MGH FMC MARI ON 193. 00 19300 NONPALD WORKERS		16, 583 0				192. 19 193. 00
193. 01 19301 MGH FMC NORTHWOOD	0	0	C	0	0	193.01
193. 02 19302 MGH FMC GAS CITY	0	0	0	274		193.02
193. 03 19303 MGH HOSPI TALI STS	0	0		0 0	0	193.03

C 193. 04 19304 M 193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M	ON - STATISTICAL BASIS	CAFETERI A (MEALS SERVED)	CAFETERIA (HOURS	OPERATI ON OF	eriod: com 07/01/2018 0 06/30/2019 LAUNDRY &	Worksheet B-1 Date/Time Pre 11/25/2019 10 HOUSEKEEPING	epared:
193. 04 19304 M 193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M		(MEALS		OPERATION OF	06/30/2019	11/25/2019 10	
193. 04 19304 M 193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M		(MEALS		OPERATI ON OF		11/25/2019 10	
193. 04 19304 M 193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M		(MEALS			LAUNDRY &		1. 50 am
193. 04 19304 M 193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M		(MEALS					
193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M			(1100113	PLANT	LINEN SERVICE	(HOURS OF	
193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M		JERVED)	WORKED)	(SQUARE	(POUNDS OF	SERVICE)	
193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M	OUL MAD FAM DDAOT		WORKED)	FEET)	LAUNDRY)	JERVICE)	
193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M	OUL MAD FAM DDAGT	6.01	6.02	7.00	8.00	9.00	
193. 05 19305 M 193. 06 19306 M 193. 07 19307 M 193. 08 19308 M	GH MAR FAM PRACT	0	0	0	847		193.04
193.06 19306 M 193.07 19307 M 193.08 19308 M		0	0	0	12		193.05
193.07 19307 M 193.08 19308 M		0	14, 403	0	44		193.06
193.08 19308 M		0	4, 378	0	0		193.07
		0	4, 370	0	25		193.08
102 00 10200 M	GH UPLAND HEALTH	0	0	0	25 1, 599		193.08
	GH MGH WOMENS CTR	0	0	0			
		-	-	-	0		193.10
	GH MGH PSYCHIATRY	0	0	0	0		193.11
193. 12 19312 0		0	0	0	0		193.12
	GH RIVER VIEW BLDG	0	0	0	0		193.15
	GH NEONATOLOGY	0	0	0	0		193.16
193.18 19318 M	GH WOUND CARE	0	0	0	0	0	193.18
194.0007963 H	EART FAILURE CLINIC	0	0	0	0	0	194.00
194.0107950 M	OW	0	0	0	0	0	194.01
194.0207951 M	ENTAL HEALTH	0	0	0	0	0	194.02
194.0307952 A		0	6, 117	0	0	0	194.03
	GH WORK SOLUTIONS	0	0	0	104	0	194.04
	GH TAYLOR UNIVERSITY	0	0	0	0		194.05
194.0807957 M		0	0	0	0		194.08
	GH AMBUCARE BLDG	0	0	0	0		194.09
	GH 106 LYONS BLDG	0	0	0	0		194.10
194. 11 07960 F		0	0	0	0		194.10
194. 12 07961 G		0	0	0	0		194.12
194. 12 07969 L		0	0	0	0		194.12
		0	0	0	0		
194.1407964 W		0	-	-	0		194.14
194. 15 07965 T		0	1, 717	0	0		194.15
	RSA NETWORK DEV PLANNING	0	1, 110	0	0		194.16
	RSA OPIOID PLANNING	0	383	0	0	0	194.17
	ross Foot Adjustments						200.00
	egative Cost Centers						201.00
	ost to be allocated (per Wkst. B,	1, 779, 631	1, 715, 868	10, 493, 488	650, 135	3, 276, 117	202.00
	art I)						
	nit cost multiplier (Wkst. B, Part I)	7.716724	1. 267667	54. 781979	0. 938667	57.959752	
P	ost to be allocated (per Wkst. B, art II)	186, 238	179, 565	3, 436, 892	115, 812	208, 269	204.00
	nit cost multiplier (Wkst. B, Part I)	0. 807554	0. 132661	17. 942532	0. 167210	3. 684612	205.00
206.00 N	AHE adjustment amount to be allocated per Wkst. B-2)						206.00
207.00 N	per wkst. B-2) AHE unit cost multiplier (Wkst. D, arts III and IV)						207.00

	I FINANCIAL SYSTEMS ALLOCATION - STATISTICAL BASIS	MARION GENER	AL HOSPITAL Provider CO	CN: 15-0011	In Lie Period:	u of Form CMS-2552-10 Worksheet B-1
00017				UN. 15 0011	From 07/01/2018 To 06/30/2019	
	Cost Center Description	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	11/25/2019 10:38 am
		10. 00	(DI RECT NRSI NG HRS)	(COSTED REQUIS.) 14.00	15.00	
	GENERAL SERVICE COST CENTERS	10.00	13.00	14.00	15.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS					6.00
6. 01	00601 CAFETERI A					6. 01
6.02						6.02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY	89, 507				10.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0		1	00	13.00 14.00
14.00	01500 PHARMACY				0 100	14.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-				
30.00	03000 ADULTS & PEDIATRICS	54, 701			14 0	30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	9, 041			4 0 0 0	31.00 40.00
40.00	04100 SUBPROVIDER - IRF	8, 109	-		1 0	40.00
42.00	04200 SUBPROVI DER	0	0		0 0	42.00
43.00	04300 NURSERY	0	31, 289		0 0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	192, 722		6 0	50.00
51.00	05100 RECOVERY ROOM	0			0 0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		3 0	54. OC
57.00	05700 CT SCAN	0	0		0 0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON		21, 893		4 0	58. 00 59. 00
60.00	06000 LABORATORY	0	0		6 0	60.00
60.01	06001 ONCOLOGY	0	0		1 0	60.01
60.02 65.00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	0	0 37, 970		0 0 6 0	60. 02 65. 00
66.00	06600 PHYSI CAL THERAPY	0	25, 165		0 0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	34, 944		3 0	69.00
69.01 71.00	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	6, 433 0		0 0 0 0	69.01 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	-		0 0	72.00
73.00		0			0 100	
~~ ~~	OUTPATIENT SERVICE COST CENTERS		0.405			
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0 1, 237			0 0	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,237	137,034		4 0	92.00
92.01		0	0		0 0	92.01
05 00		0	49, 298		1 0	05.00
93.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	49, 290		1 0	95.00
	11300 INTEREST EXPENSE					113.00
118.00		73, 088	857, 140	!	53 100	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	0		0 0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	-		0 0	192.00
	2 19202 VISITOR MEALS	0	0		0 0	192.02
	3 19203 GREAT BEGI NNI NGS/MATERNAL 4 19204 LI FELI NE	0	3, 937		0 0	192. 03 192. 04
	19204 LIFELINE 19205 OWNED PROPERTIES		0		0 0	192.04
	19206 UROLOGY	0	0		3 0	192.06
	3 19211 PARI SH NURSI NG	0	0		0 0	192.08
	9 19212 BI OTERRORI SM GRANT D 19214 BREAST PUMPS		0			192. 09 192. 10
	1 19208 MGH EMERGENCY PHYSICIANS	0	0		0 0	192.11
192.12	2 19209 LUNG CENTER	0	0		0 0	192. 12
	19213 MGH EXPRESS	0	19, 333		0 0	192. 13 192. 14
	4 19210 MGH PHYS PRACT MGMT 5 19215 MGH MARION SURGEONS		0		4 0	192.14
192.16	5 19216 MGH MGH MED ONC	0	0		0 0	192.16
	7 19217 MGH FMC SOUTH	0	0		4 0	192. 17
	3 19218 MGH FAIRM MED ASSOC 9 19219 MGH FMC MARION	0	0		0 0	192. 18 192. 19
	19219 MGH FMC MARION 19300 NONPALD WORKERS		0			192. 19
	1 19301 MGH FMC NORTHWOOD	0	0		1 0	193.01
	2 19302 MGH FMC GAS CITY	0	0	1	2 0	193.02

Heal th Finar	ncial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1
					From 07/01/2018	
					To 06/30/2019	
	Cost Center Description	DI ETARY	NURSI NG	CENTRAL	PHARMACY	11/25/2019 10:38 am
	Cost center bescription	(MEALS	ADMI NI STRATI O	SERVICES &	(COSTED	
		SERVED)	N	SUPPLY	REQUIS.)	
		JERVED)	(DI RECT	(COSTED	RE2013.)	
			NRSING HRS)	REQUIS.)		
		10.00	13.00	14.00	15.00	
193.0319303	MGH HOSPI TALI STS	0			0 0	193.03
	MGH MAR FAM PRACT	0	0		4 0	193.04
193.05 19305	MGH FMC SWAYZEE	0	0		2 0	193.05
193.06 19306	MGH PEDIATRIC CTR	0	0		1 0	193.06
193.07 19307	MGH SPECIALTY PHYS	0	0		0 0	193.07
193.08 19308	MGH FMC CONVERSE	0	0		1 0	193.08
193.0919309	MGH UPLAND HEALTH	0	0		6 0	193.09
193. 10 19310	MGH MGH WOMENS CTR	0	0		0 0	193.10
193. 11 19311	MGH MGH PSYCHLATRY	0	0		0 0	193. 11
193. 12 19312	OB/GYN	0	0	1	1 0	193.12
	MGH RIVER VIEW BLDG	0	0		0 0	193. 15
193. 16 19316	MGH NEONATOLOGY	0	0		0 0	193.16
193. 18 19318	MGH WOUND CARE	0	0		0 0	193. 18
194.0007963	HEART FAILURE CLINIC	0	0		0 0	194.00
194.0107950	MOW	6, 252	0		0 0	194.01
194. 02 07951	MENTAL HEALTH	10, 167	0		0 0	194.02
	ADVERTI SI NG	0	0		0 0	194.03
194.0407953	MGH WORK SOLUTIONS	0	0		4 0	194.04
194.0507954	MGH TAYLOR UNIVERSITY	0	0		0 0	194.05
194.0807957	MGH SMMP BLDG	0	0		0 0	194.08
194.0907958	MGH AMBUCARE BLDG	0	0		0 0	194.09
194. 10 07959	MGH 106 LYONS BLDG	0	0		0 0	194.10
194.1107960	FAI RMOUNT	0	0		0 0	194.11
194. 12 07961	GAS CITY	0	0		0 0	194.12
194. 13 07969	LYONS	0	0		0 0	194.13
194. 14 07964		0	0		0 0	194.14
194. 15 07965	TOBACCO GRANT	0	0		0 0	194.15
194. 16 07966	HRSA NETWORK DEV PLANNING	0	0		0 0	194.16
194. 17 07967	HRSA OPIOLD PLANNING	0	0		2 0	194.17
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	1, 330, 251	1, 520, 171	856, 26	4 5, 557, 978	202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	14. 861977	1. 726663	8, 562. 64000	0 55, 579. 780000	203.00
204.00	Cost to be allocated (per Wkst. B,	359, 744	64, 704	139, 29	8 258, 405	204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	4. 019172	0. 073493	1, 392. 98000	0 2, 584. 050000	205.00
	11)					
206.00	NAHE adjustment amount to be allocated					206.00
	(per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D,					207.00
	Parts III and IV)		I			l I

Health Fii	nancial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-3	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0011	Period:	Worksheet C	
					From 07/01/2018	Part I	norod.
					To 06/30/2019	Date/Time Pre 11/25/2019 10	
			Title	XVIII	Hospi tal	PPS	<u>. 00 ull</u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	PATIENT ROUTINE SERVICE COST CENTERS	47 704 470		47 704 47		47 704 470	
	000 ADULTS & PEDIATRICS	17, 731, 170		17, 731, 17		17, 731, 170	
	100 INTENSIVE CARE UNIT	5, 293, 276		5, 293, 27	6 0	5, 293, 276	
	000 SUBPROVIDER - IPF	0 701 10(0 704 40	0 0	0	
	100 SUBPROVI DER – I RF	3, 701, 486		3, 701, 48	6 0	3, 701, 486	
	200 SUBPROVI DER	1 707 011		1 707 01	0 0	0	
	300 NURSERY CI LLARY SERVI CE COST CENTERS	1, 737, 011		1, 737, 01	1 0	1, 737, 011	43.00
	DOO OPERATING ROOM	18, 353, 493		18, 353, 49	3 0	18, 353, 493	50.00
	100 RECOVERY ROOM	10, 303, 493		10, 303, 49	0 0	16, 333, 493	
	400 RADI OLOGY-DI AGNOSTI C	8, 923, 268		8, 923, 26		8, 923, 268	
	700 CT SCAN	1, 617, 573		1, 617, 57		1, 617, 573	
	BOO MAGNETIC RESONANCE IMAGING (MRI)	909, 968		909, 96		909, 968	
	900 CARDI AC CATHETERI ZATI ON	2, 920, 214		2, 920, 21		2, 920, 214	
	DOO LABORATORY	11, 568, 725		11, 568, 72		11, 568, 725	
	DO1 ONCOLOGY	2, 269, 621		2, 269, 62		2, 269, 621	
	DO2 RADIATION ONCOLOGY	2,207,021		2,207,02	0 0	2,207,021	
	500 RESPI RATORY THERAPY	3, 672, 833	0	3, 672, 83	3 0	3, 672, 833	
	600 PHYSI CAL THERAPY	3, 206, 668	0	3, 206, 66		3, 206, 668	
	900 ELECTROCARDI OLOGY	2, 390, 936	0	2, 390, 93		2, 390, 936	•
	901 CARDI AC REHAB	507, 865		507, 86		507,865	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
	200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 073	300 DRUGS CHARGED TO PATIENTS	15,041,052		15,041,05	2 0	15,041,052	73.00
	TPATIENT SERVICE COST CENTERS						
90.00 090	DOO CLINIC	1, 413, 078		1, 413, 07	8 0	1, 413, 078	90.00
91.00 091	100 EMERGENCY	11, 259, 030		11, 259, 03	0 0	11, 259, 030	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 558, 409		3, 558, 40	19	3, 558, 409	92.00
92.01 092	201 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0	92.01
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	2, 302, 505		2, 302, 50	5 0	2, 302, 505	95.00
	ECIAL PURPOSE COST CENTERS	1					
	300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	118, 378, 181	0				
201.00	Less Observation Beds	3, 558, 409		3, 558, 40		3, 558, 409	
202.00	Total (see instructions)	114, 819, 772	0	114, 819, 77	2 0	114, 819, 772	202.00

Health Financial Syste	ms	MARI ON GENERAL	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO C	OF COSTS TO CHARGES		Provider C		Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Pre 11/25/2019 10	
			Title	XVIII	Hospi tal	PPS	<u>, , , , , , , , , , , , , , , , , , , </u>
			Charges				
Cost Cente	er Description	I npati ent	Outpatient	Total (col. 6	Cost or Other	TEFRA	
	·			+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7.00	8.00	9.00	10.00	
	NE SERVICE COST CENTERS						
30.00 03000 ADULTS & F		17, 405, 375		17, 405, 37			30.00
31.00 03100 I NTENSI VE		6, 910, 126		6, 910, 12	6		31.00
40.00 04000 SUBPROVI DE	ER – IPF	0			0		40.00
41.00 04100 SUBPROVI DE		3, 619, 018		3, 619, 01	8		41.00
42.00 04200 SUBPROVI DE	R	0		(0		42.00
43.00 04300 NURSERY		2, 486, 224		2, 486, 22	4		43.00
ANCI LLARY SERVI	CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			· · · · · · · · · · · · · · · · · · ·		
50.00 05000 OPERATI NG	ROOM	33, 648, 820	74, 776, 303	108, 425, 12	3 0. 169273	0.00000	50.00
51.00 05100 RECOVERY F	ROOM	0	0	(0. 000000	0.000000	51.00
54.00 05400 RADI OLOGY-	DI AGNOSTI C	2, 065, 720	32, 658, 868	34, 724, 58	8 0. 256973	0.000000	54.00
57.00 05700 CT SCAN		4, 515, 701	29, 293, 872	33, 809, 57	3 0. 047844	0.00000	57.00
58.00 05800 MAGNETIC F	RESONANCE IMAGING (MRI)	316, 626	2, 952, 617	3, 269, 24	3 0. 278342	0.00000	58.00
59.00 05900 CARDI AC CA	ATHETERI ZATI ON	2, 944, 950	5, 158, 912	8, 103, 86	2 0. 360348	0.00000	59.00
60.00 06000 LABORATORY	1	3, 729, 229	14, 380, 572	18, 109, 80	0. 638810	0.00000	60.00
60.01 06001 ONCOLOGY		26, 837	7, 583, 431			0.00000	60.01
60. 02 06002 RADI ATI ON	ONCOLOGY	0	0		0. 000000	0.000000	
65. 00 06500 RESPI RATOR		2, 632, 327	6, 153, 357	8, 785, 68		0.000000	
66.00 06600 PHYSI CAL		5, 157, 649	5, 488, 208			0.000000	
69.00 06900 ELECTROCAR		3, 891, 951	8, 666, 882			0. 000000	
69. 01 06901 CARDI AC RE		1,000	1, 079, 233			0. 000000	
	JPPLIES CHARGED TO PATIENTS	0	1, 0, 7, 200		0. 000000	0. 000000	
	CHARGED TO PATIENTS	0	0		0.000000	0. 000000	
73.00 07300 DRUGS CHAP		8, 386, 817	83, 860, 149	92, 246, 96		0. 000000	
	ICE COST CENTERS	0, 300, 017	03,000,147	72,240,70	0. 103032	0.00000	/ / 0.00
90. 00 09000 CLINIC		8,000	1, 921, 237	1, 929, 23	7 0. 732454	0. 000000	90.00
91.00 09100 EMERGENCY		12, 619, 694	65, 661, 719			0. 000000	
	N BEDS (NON-DISTINCT PART)	12,017,074	8, 193, 383			0. 000000	
	DN BEDS (DISTINCT PART)	0	0, 173, 303		0. 434303	0. 000000	
	BLE COST CENTERS	0	0		0.000000	0.00000	92.01
95.00 09500 AMBULANCE		0	4, 423, 618	4, 423, 61	8 0. 520503	0. 000000	95.00
SPECIAL PURPOSE		U	4, 423, 018	4, 423, 01	0. 020503	0.00000	95.00
113.00 11300 I NTEREST E		Г					113.00
	see instructions)	110, 366, 064	352, 252, 361	462, 618, 42	5		200.00
	vation Beds	110, 300, 004	JJZ, ZJZ, 301	402, 010, 42			200.00
	e instructions)	110, 366, 064	352, 252, 361	462, 618, 42	5		201.00
202.00 10101 (See		110, 300, 004	JJZ, ZJZ, JOI	+02, 010, 42			202.00

Health Financial Systems	MARION GENERAL HOSPITAL In Lieu of Form CMS-				
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Pre 11/25/2019 10	pared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
40. 00 04000 SUBPROVIDER - IPF					40.00
41. 00 04100 SUBPROVI DER – I RF					41.00
42. 00 04200 SUBPROVI DER					42.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS	<u>I</u> I				
50. 00 05000 OPERATI NG ROOM	0. 169273				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 256973				54.00
57. 00 05700 CT SCAN	0.047844				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 278342				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 360348				59.00
60. 00 06000 LABORATORY	0. 638810				60.00
60. 01 06000 LABORATORY 60. 01 06001 0NC0L0GY	0. 298231				60.00
60. 02 06002 RADIATION ONCOLOGY	0. 298231				60.01
65. 00 06500 RESPIRATORY THERAPY	0. 418047				65.00
66. 00 06600 PHYSI CAL THERAPY	0.301213				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 190379				69.00
69. 01 06901 CARDI AC REHAB	0. 470144				69.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.00000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.00000				72.00
73.00 07300 DRUGS CHARGED TO PATI ENTS	0. 163052				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 732454				90.00
91.00 09100 EMERGENCY	0. 143828				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 434303				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0. 520503				95.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0011	Peri od:	Worksheet C	
					From 07/01/2018	Part I	
					To 06/30/2019	Date/Time Pre 11/25/2019 10	epared:
			Ti +I	e XIX	Hospi tal	Cost	<u>. 30 alli</u>
			11.01		Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj.		Di sal I owance	iotal ocoto	
		B, Part I,	.,				
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	17, 731, 170		17, 731, 1	70 0	17, 731, 170	30.00
	03100 INTENSIVE CARE UNIT	5, 293, 276		5, 293, 2	76 0	5, 293, 276	31.00
	04000 SUBPROVI DER – I PF	0			0 0	0	40.00
	04100 SUBPROVI DER – I RF	3, 701, 486		3, 701, 48	36 0	3, 701, 486	41.00
	04200 SUBPROVI DER	0			0 0	0	
	04300 NURSERY	1, 737, 011		1, 737, 0	1 0	1, 737, 011	43.00
	ANCILLARY SERVICE COST CENTERS			1	- 1		
	05000 OPERATING ROOM	18, 353, 493		18, 353, 49			1
	05100 RECOVERY ROOM	0			0 0		
	05400 RADI OLOGY-DI AGNOSTI C	8, 923, 268		8, 923, 20		8, 923, 268	
	05700 CT SCAN	1, 617, 573		1, 617, 5		1, 617, 573	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	909, 968		909, 90		909, 968	
	05900 CARDI AC CATHETERI ZATI ON	2, 920, 214		2, 920, 2		2, 920, 214	1
	06000 LABORATORY	11, 568, 725		11, 568, 72		11, 568, 725	
	06001 ONCOLOGY	2, 269, 621		2, 269, 62	21 0	2, 269, 621	
	06002 RADI ATI ON ONCOLOGY	0	0	0 (70 0)	0 0	0	
	06500 RESPI RATORY THERAPY	3, 672, 833	0	3, 672, 83		3, 672, 833	
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	3, 206, 668	0	3, 206, 60		3, 206, 668	
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	2, 390, 936 507, 865		2, 390, 93 507, 80		2, 390, 936 507, 865	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	507,865		507,80	0 0	507,865	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0		
	07300 DRUGS CHARGED TO PATIENTS	15, 041, 052		15, 041, 0		-	
	OUTPATIENT SERVICE COST CENTERS	15,041,052		15,041,0	02 0	15, 041, 052	/3.00
	09000 CLINIC	1, 413, 078		1, 413, 0	78 0	1, 413, 078	90.00
	09100 EMERGENCY	11, 259, 030		11, 259, 03		11, 259, 030	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 558, 409		3, 558, 40		3, 558, 409	
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	3, 330, 409		3, 330, 40	0 0		1
	OTHER REIMBURSABLE COST CENTERS	0			0 0	0	72.01
	09500 AMBULANCE SERVICES	2, 302, 505		2, 302, 50	05 0	2, 302, 505	95.00
	SPECIAL PURPOSE COST CENTERS	2, 302, 303		2,302,30	0	2, 302, 303	/3.00
	11300 I NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	118, 378, 181	0	118, 378, 18	31 0	118, 378, 181	
201.00	Less Observation Beds	3, 558, 409	-	3, 558, 40		3, 558, 409	
202.00	Total (see instructions)	114, 819, 772					
					1		

Health Fir	nancial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0011	Period: From 07/01/2018	Worksheet C Part I	
					To 06/30/2019	Date/Time Pre	epared:
			T: +1		lleen: tel	11/25/2019 10	<u>):38 am</u>
			Charges	e XIX	Hospi tal	Cost	
	Cost Center Description	Inpatient	Outpati ent	Total (col)	6 Cost or Other	TEFRA	
		inputront	outputtent	+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	DOO ADULTS & PEDIATRICS	17, 405, 375		17, 405, 37	5		30.00
	IOO INTENSIVE CARE UNIT	6, 910, 126		6, 910, 12	6		31.00
	000 SUBPROVI DER – I PF	0			0		40.00
	IOO SUBPROVI DER – I RF	3, 619, 018		3, 619, 01	8		41.00
	200 SUBPROVI DER	0			0		42.00
	300 NURSERY	2, 486, 224		2, 486, 22	4		43.00
	CILLARY SERVICE COST CENTERS						
	DOO OPERATING ROOM	33, 648, 820	74, 776, 303				1
	OO RECOVERY ROOM	0	0		0 0.00000		
	100 RADI OLOGY-DI AGNOSTI C	2,065,720	32, 658, 868				
	700 CT SCAN	4, 515, 701	29, 293, 872			0.00000	
	BOO MAGNETIC RESONANCE IMAGING (MRI)	316, 626	2, 952, 617			0.00000	
	200 CARDI AC CATHETERI ZATI ON	2, 944, 950	5, 158, 912				
		3, 729, 229	14, 380, 572				
	001 ONCOLOGY	26, 837	7, 583, 431			0.00000	
	002 RADI ATI ON ONCOLOGY	0	0		0 0.00000		
		2, 632, 327	6, 153, 357			0.00000	
		5, 157, 649	5, 488, 208				
		3, 891, 951	8, 666, 882				
		1,000	1, 079, 233			0.00000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.00000 0 0.000000	0.00000	
		0	02 0(0 140	02 244 04			
	BOO DRUGS CHARGED TO PATIENTS PATIENT SERVICE COST CENTERS	8, 386, 817	83, 860, 149	92, 246, 96	6 0. 163052	0.00000	73.00
	DOO CLINIC	8,000	1, 921, 237	1, 929, 23	7 0. 732454	0. 000000	90.00
		12, 619, 694	65, 661, 719				
	200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 019, 094	8, 193, 383				
	201 OBSERVATION BEDS (DISTINCT PART)	0	0, 173, 303		0. 000000		
	IER REIMBURSABLE COST CENTERS	U	0		0 0.00000	0.00000	92.01
	500 AMBULANCE SERVICES	0	4, 423, 618	4, 423, 61	8 0. 520503	0. 000000	95.00
	CIAL PURPOSE COST CENTERS	0	4, 423, 010	4, 423, 01	0. 320303	0.00000	/3.00
	BOO INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	110, 366, 064	352, 252, 361	462, 618, 42	5		200.00
201.00	Less Observation Beds	,,,	,, 001		-		201.00
202.00	Total (see instructions)	110, 366, 064	352, 252, 361	462, 618, 42	5		202.00
I I					1		

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Pre 11/25/2019 10	pared: :38 am
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVI DER – I PF					40.00
41.00	04100 SUBPROVIDER - IRF					41.00
42.00	04200 SUBPROVI DER					42.00
	04300 NURSERY					43.00
	ANCI LLARY SERVICE COST CENTERS	1				
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
	05700 CT SCAN	0. 000000				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 000000				60.00
	06001 ONCOLOGY	0. 000000				60.00
	06002 RADIATION ONCOLOGY	0. 000000				60.01
	06500 RESPIRATORY THERAPY	1				65.00
	06600 PHYSI CAL THERAPY	0.000000				66.00
	06900 ELECTROCARDI OLOGY	0. 000000				69.00
	06901 CARDI AC REHAB	0. 000000				69.01
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
	09000 CLINIC	0. 000000				90.00
	09100 EMERGENCY	0. 000000				91.00
	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	1				
95.00	09500 AMBULANCE SERVICES	0. 000000				95.00
	SPECIAL PURPOSE COST CENTERS	1 1				
	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	Provider CCN: 15-0011 Period:			
				From 07/01/2018 To 06/30/2019		norod.
				10 06/30/2019	11/25/2019 10	
		Title	XVIII	Hospi tal	PPS	<u>. 00 am</u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost	-	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	T	1	1			
30. 00 ADULTS & PEDIATRICS	2, 792, 889		2, 792, 88		165.19	
31.00 INTENSIVE CARE UNIT	657, 940		657, 94	3, 749	175.50	
40.00 SUBPROVIDER – IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER – IRF	592, 228	0	592, 22	8 2, 821	209.94	
42. 00 SUBPROVI DER	0	0		0 0	0.00	
43.00 NURSERY	34, 808		34, 80		18. 22	43.00
200.00 Total (lines 30 through 199)	4, 077, 865		4, 077, 86	5 25, 387		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			1			
30.00 ADULTS & PEDIATRICS	5, 955					30.00
31.00 INTENSIVE CARE UNIT	1, 175	206, 213				31.00
40. 00 SUBPROVI DER – I PF	0	0				40.00
41.00 SUBPROVIDER - IRF	2, 091	438, 985				41.00
42.00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	9, 221	1, 628, 904	1			200.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 10	
			XVIII	Hospi tal PPS		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2,068,446	108, 425, 123			231, 722	50.00
51.00 05100 RECOVERY ROOM	0	-	0.00000	· · · ·		51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 217, 999	34, 724, 588	0. 03507	76 934, 943	32, 794	54.00
57.00 05700 CT SCAN	107, 137	33, 809, 573	0.00316	2, 371, 789	7, 516	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	105, 447	3, 269, 243	0. 03225	54 155, 924	5, 029	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	311, 541	8, 103, 862	0. 03844	1, 330, 930	51, 166	59.00
60. 00 06000 LABORATORY	857, 947	18, 109, 801	0.04737	1, 699, 007	80, 490	60.00
60. 01 06001 ONCOLOGY	38, 968	7, 610, 268	0.00512	20 25, 354	130	60.01
60. 02 06002 RADIATION ONCOLOGY	0	0	0. 00000	0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	304, 466	8, 785, 684	0. 03465	5 1, 198, 096	41, 520	65.00
66.00 06600 PHYSI CAL THERAPY	106, 604	10, 645, 857	0.01001	4 1, 056, 834	10, 583	66.00
69.00 06900 ELECTROCARDI OLOGY	455, 850	12, 558, 833	0. 03629	1, 864, 651	67, 681	69.00
69. 01 06901 CARDI AC REHAB	79, 339	1, 080, 233	0.07344	6 592	43	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000	0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	381, 853	92, 246, 966	0.00413	3, 422, 438	14, 165	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	169, 387	1, 929, 237	0.08780	0 7,805	685	90.00
91.00 09100 EMERGENCY	862, 760					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	560, 496	8, 193, 383	0.06840		0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		1	0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS				- 1		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	7, 628, 240	427, 774, 064		31, 600, 216	602, 874	

40.00 04000 SUBPROVI DER - IPF 0	Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments Nursing Post-Stepdown Adjustments Nursing Post-Stepdown Adjustme	APPORTIONMENT OF INPATIENT ROUTINE SERVICE	OTHER PASS THROUGH COS			From 07/01/2018	Part III Date/Time Pre	pared: 0:38 am
School Post-Stepdown Adjustments School Adjustments Post-Stepdown Adjustments Cost Adjustments Medical Education Cost 30.00 03000 ADULTS & PEDIATRICS 0							
INPATI ENT ROUTINE SERVICE COST CENTERS Adjustments Education Cost 0.00 03000 ADULTS & PEDIATRICS 0 <	Cost Center Description						
Adjustments Cost 1A 1.00 2A 2.00 3.00 30.00 0000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 31.00 03000 ADULTS & PEDIATRICS 0<					n Cost	Medi cal	
INPATI ENT ROUTINE SERVICE COST CENTERS 1A 1.00 2A 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 0				Adjustments			
INPATIENT ROUTINE SERVICE COST CENTERS 0							
30.00 03000 ADULTS & PEDIATRICS 0			1.00	2A	2.00	3.00	
31.00 03100 INTENSIVE CARE UNIT 0			-	1	-	-	
40.00 04000 SUBPROVI DER - IPF 0		-	-			0	
41.00 04100 SUBPROVI DER - IRF 0					0 0	-	
42.00 04200 SUBPROVI DER 0 0 0 0 0 42.00 43.00 04300 NURSERY 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>		0	0		0 0	-	
43.00 04300 NURSERY 0		0	0		0 0		•
200.00 Total (lines 30 through 199) 0		0	0		0 0	-	
Cost Center Description Swing-Bed Adjustment Total Costs (sum of cols. 1 through 3, minus col. 4) Total Patient Days Per Diem (col. 5 ÷ col. 6) Inpatient Program Days 30.00 03000 ADULTS & PEDIATRICS 0 0 16,907 0.00 5,955 30.00 31.00 03000 INTENSIVE CARE UNIT 0 0 16,907 0.00 5,955 30.00 42.00 04000 SUBPROVI DER - IPF 0 0 0 0 0 2,821 0.00 2,091 41.00 43.00 04300 NURSERY SubpRovi DER 1 RF 0 0 1,910 0.00 0 43.00 200.00 Total (lines 30 through 199) Inpatient Program Program Pass-Through Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9,00 25,387 9,221 200.00		0	0		0 0	-	
Adj ustment Amount (see instructions) Gum of col s. 1 through 3, minus col . 4) Days (col . 5 + col . 6) Program Days 30.00 03000 ADULTS & PEDIATRICS 0 0 0.00 7.00 8.00 31.00 03100 INTENSI VE CARE UNIT 0 0 16,907 0.00 5,955 30.00 40.00 04000 SUBPROVI DER - 1PF 0 0 3,749 0.00 1,175 31.00 41.00 04100 SUBPROVI DER - 1 RF 0 0 0 0.00 2,821 0.00 2,091 41.00 42.00 04200 SUBPROVI DER 1 Inpati ent Program 0 0 0 0 0 43.00 200.00 Total (Lines 30 through 199) Inpati ent Program Program Pass-Through Cost (col . 7 x col . 8) 9.00 25,387 9,221 200.00		0			0 0		200.00
Amount (see instructions) 1 through 3, minus col. 4) col. 6) col. 6) 30.00 03000 ADULTS & PEDIATRICS 0 0.00 7.00 8.00 31.00 03000 INTENSI VE CARE UNIT 0 3,749 0.00 1,175 31.00 40.00 04000 SUBPROVI DER - IPF 0 0 0,00 0,000	Cost Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS instructions) minus col. 4) A.00 5.00 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0 16,907 0.00 5,955 30.00 31.00 03100 INTENSIVE CARE UNIT 0 3,749 0.00 42.00 40.00 40.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 43.00 43.00 43.00 43.00 43.00				Days		Program Days	
4.00 5.00 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0 16,907 0.00 5,955 30.0 31.00 03100 INTENSIVE CARE UNIT 0 3,749 0.00 1,175 31.0 40.00 04000 SUBPROVI DER - IPF 0 0 0 2,821 0.00 2,091 41.0 42.00 04200 SUBPROVI DER IRF 0 0 0 0.00 0 42.00 200.00 UNRSERY 0 0 0 0 0 0 0 43.00 04300 NURSERY 0 0 0 43.00 25,387 9,221 200.00 43.00 Void Inpatient Program Pass-Through 0 25,387 9,221 200.00 0 0.01 7,900 0 20.00 0 0 0 0 0					COL 6)		
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRICS 0 0 16,907 0.00 5,955 30.0 31.00 03100 INTENSIVE CARE UNIT 0 0 3,749 0.00 1,175 31.0 40.00 04000 SUBPROVIDER - IPF 0 0 0 0 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 2,821 0.00 2,091 41.0 42.00 04200 SUBPROVIDER 0 0 0 0 0 42.00 04300 NURSERY 0 0 0 0 42.00 200.00 Total (lines 30 through 199) 0 25,387 9,221 200.00 Cost Center Description Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 9.00 0 0				6.00	7.00	8.00	
30.00 03000 ADULTS & PEDIATRICS 0 16,907 0.00 5,955 30.0 31.00 03100 INTENSIVE CARE UNIT 0 3,749 0.00 1,175 31.0 40.00 04000 SUBPROVIDER - IPF 0 0 0 0 0 0 40.0 41.00 04100 SUBPROVIDER - IRF 0 0 0 2,821 0.00 2,091 41.0 42.00 04200 SUBPROVIDER IRF 0 0 0 0 0 42.00 43.00 04300 NURSERY 0 0 1,910 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 25,387 9,221 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 9.00	INPATIENT ROUTINE SERVICE COST CENTER		0.00	0.00	7.00	0.00	
31.00 03100 INTENSIVE CARE UNIT 0 3,749 0.00 1,175 31.0 40.00 04000 SUBPROVIDER - IPF 0 0 0 0.00 0 40.0 41.00 04000 SUBPROVIDER - IPF 0 0 0 0.00 0 40.0 42.00 04200 SUBPROVIDER - IRF 0 0 0 2,821 0.00 2,091 41.0 43.00 04300 NURSERY 0 0 0 0 0 42.0 200.00 Total (lines 30 through 199) 0 0 25,387 9,221 200.0 Cost Center Description Inpatient Program Pass-Through Cost (col.7) x col.8) 9.00 9.00 9.00			0	16.90	7 0.00	5, 955	30.00
40.00 04000 SUBPROVI DER - IPF 0 0 0 0.00 0 40.00 41.00 04100 SUBPROVI DER - IRF 0 0 2,821 0.00 2,091 41.00 42.00 04200 SUBPROVI DER 0 0 0 0 0 42.00 43.00 04300 NURSERY 0 0 0 0 0 43.00 200.00 Total (lines 30 through 199) 0 25,387 9,221 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 40.00 40.00		_					
41.00 04100 SUBPROVI DER - IRF 0 0 2,821 0.00 2,091 41.0 42.00 04200 SUBPROVI DER 0 0 0 0 0 42.0 43.00 04300 NURSERY 0 1,910 0.00 0 43.0 200.00 Total (Lines 30 through 199) 0 25,387 9,221 200.0 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		0	0				•
42.00 04200 SUBPROVI DER 0 0 0 0.00 0 42.00 43.00 04300 NURSERY 0 1,910 0.00 0 43.00 200.00 Total (Lines 30 through 199) 0 25,387 9,221 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9,00 42.0		-	-				
43.00 04300 NURSERY 0 1,910 0.00 0 43.0 200.00 Total (lines 30 through 199) 0 25,387 9,221 200.0 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9,00 0 43.0			0				•
200.00 Total (lines 30 through 199) 0 25, 387 9, 221 200.0 Cost Center Description Program Pass-Through Cost (col. 7 x col. 8) 9, 00		_		1, 91			•
Cost Center Description Program Pass-Through Cost (col. 7 x col. 8) 9.00							
Pass-Through Cost (col. 7 <u>x col. 8)</u> 9.00		I npati ent		• · · ·			
Cost (col. 7 x col. 8) 9.00		Program					
<u>x col . 8)</u> 9.00		Pass-Through					
9.00							
		x col. 8)					
INPATIENT ROUTINE SERVICE COST CENTERS							
			1				
							30.00
							31.00
		°					40.00
							41.00
		-					42.00
							43.00
200.00 Total (lines 30 through 199) 0 200.0	200.00 lotal (lines 30 through 199)	0	1				200.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	VICE OTHER PASS Provider CCN: 15-00 Title XVIII		Period: From 07/01/2018 To 06/30/2019			
		Title	XVIII	Hospi tal		PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health		
	Anesthetist	School	School	Post-Stepdown			
	Cost	Post-Stepdown		Adjustments			
		Adjustments					
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS	-						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00	
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00	
57.00 05700 CT SCAN	0	0		0 0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00	
60. 00 06000 LABORATORY	0	0		0 0	0	60.00	
60. 01 06001 0NC0L0GY	0	0		0 0	0	60. 01	
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0	60. 02	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00	
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00	
69. 01 06901 CARDI AC REHAB	0	0		0 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	0	0		0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	0		0 0	0	90.00	
91.00 09100 EMERGENCY	0	0	1	0 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01	
OTHER REIMBURSABLE COST CENTERS	·					1	
95. 00 09500 AMBULANCE SERVICES						95.00	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00	

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0011 Period: From 07/01/2018 Porcksheet D Tordal Cost THROUGH COSTS Cost Center Description All Other Medical Education Cost Total Cost Total Cost (sum of cost (sum of cos	Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-10			
Cost Center Description All Other Medical Education Cost Total (sum of cols. 4) Total Cost (sum of cols. 4) Total Cost (sum of cols. and 4) Total Cost (sum of cols. col. 5) Total Cost (sot (sum of cols. 2, 3) Total Cost (sot (sum of cols. 2) Total Cost (sot (sot (sot (sot (sot (sot (sot (sot		S Provider C		From 07/01/2018	Part IV Date/Time Pre			
Medical Education 0 State Medical Education 0 State Outpatient (Sum of cols. ot) Outpatient (Sum of cols. cols. cols. and 4) (from Wkst. cols. cols. and 4) to Charges (col. col. col. b ANCILLARY SERVICE COST CENTERS			Title	XVIII				
Education Cost 1, 2, 3, and 4) Cost Cst C, Part I, col s. 2, 3, and 4) (col. 5 + col. 7) ANCILLARY SERVICE COST CENTERS 50.00 05000 (PERATING ROOM 0	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
ANCI LLARY SERVICE COST CENTERS Col . 2, 3, and 4) Col . 7) And 4) ANCI LLARY SERVICE COST CENTERS		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges		
And (a) and (a) <t< td=""><td></td><td>Educati on</td><td>1, 2, 3, and</td><td>Cost (sum of</td><td>C, Part I,</td><td>(col. 5 ÷</td><td></td></t<>		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷		
ANCI LLARY SERVICE COST CENTERS O 0 </td <td></td> <td>Cost</td> <td>4)</td> <td></td> <td>col. 8)</td> <td>col. 7)</td> <td></td>		Cost	4)		col. 8)	col. 7)		
ANCI LLARY SERVICE COST CENTERS ODE								
50.00 05000 OPERATI NG ROOM 0 0 0 0 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 54.00 OS400 RAD IOLGCY-DI AGNOSTI C 0 0 0 0.000000 51.00 54.00 O5400 RAD IOLGCY-DI AGNOSTI C 0 0 0 33.809,573 0.000000 57.00 58.00 O5800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 3.269,243 0.000000 58.00 59.00 O5000 CARDI AC CATHETERI ZATI ON 0 0 0 8.103,862 0.000000 60.01 60.01 06001 NOCLOGY 0 0 0 7.610,268 0.000000 60.01 60.02 RADI ATI ON ONCOLOGY 0 0 0 7.610,268 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 8.785,684 0.000000 65.00 60.00 06900 LECTROCARDI OLGY 0 0 0 0.00		4.00	5.00	6.00	7.00	8.00		
51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 54.00 05400 RADI DLOGY-DI AGNOSTI C 0 0 33,809,573 0.000000 54.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 33,809,573 0.000000 58.00 59.00 05900 C ARDI AC CATHETERI ZATI ON 0 0 8,103,862 0.000000 59.00 60.01 06000 LABORATORY 0 0 0 8,103,862 0.000000 60.01 60.01 06001 NCOLOGY 0 0 0 7,610,268 0.000000 60.01 60.02 06020 RADI ATI ON ONCOLOGY 0 0 0 0.000000 60.01 60.00 06500 RESPI RATORY THERAPY 0 0 0 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 10,645,857 0.000000 69.00 60.00 06900 LECTROCARDI OLOGY 0 0 0 0.000000 71.00 0.000000		I		1			-	
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 34, 724, 588 0.000000 54.00 57.00 05700 CT SCAN 0 0 33, 809, 573 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 3, 269, 243 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 8.103, 862 0.000000 59.00 60.01 06001 LABORATORY 0 0 18.109, 801 0.000000 60.01 60.02 06002 RADIATION ONCOLOGY 0 0 0 0.000000 60.01 60.02 06500 RESPIRATORY THERAPY 0 0 0 0.000000 60.02 65.00 06500 RESPIRATORY THERAPY 0 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 10.645, 857 0.000000 69.00 69.00 06900 ELECTROCARDI DLOGY 0 0 1.080, 233 0.000000 72.00 72.00 72.00		0	0					
57.00 05700 CT SCAN 0 0 33,809,573 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 3,269,243 0.000000 58.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 8,103,862 0.000000 59.00 60.00 LABORATORY 0 0 0 18,109,801 0.000000 60.01 60.01 06001 ONCOLOGY 0 0 0 0 0.000000 60.01 60.02 CAGDI ANCOLOGY 0 0 0 0 0.000000 60.01 60.02 CAGO2 RADI ATI ON ONCOLOGY 0 0 0 0.000000 60.02 65.00 D6500 RESPI RATORY THERAPY 0 0 0 0.000000 65.00 66.00 O6600 PHYSI CAL THERAPY 0 0 0 10.645,857 0.000000 69.01 67.00 G6900 ELECTROCARDI OLOGY 0 0 0 0.000000 71.00 71.00 OF100<		0	0					
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 3, 269, 243 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 8, 103, 862 0.000000 59.00 60.01 06001 NAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 8, 103, 862 0.000000 59.00 60.01 06001 NCOLOGY 0 0 18, 109, 801 0.000000 60.01 60.02 06002 RADI ATI ON ONCOLOGY 0 0 0 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 10, 645, 857 0.000000 66.00 69.01 06901 CARDI AC REHAB 0 0 0 1, 080, 233 0.000000 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0		0	0					
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 8, 103, 862 0.00000 59.00 60.00 06000 LABORATORY 0 0 18, 109, 801 0.000000 60.00 60.01 06001 ONCOLOGY 0 0 7, 610, 268 0.000000 60.02 60.02 RADI ATI ON ONCOLOGY 0 0 0 0 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 8, 785, 684 0.000000 65.00 67.00 06900 ELECTROCARDI OLOGY 0 0 0 10, 645, 857 0.000000 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 72.00 72.00 72.00 72.00 72.00 73.00 0 0 0 0 0.000000 72.00 73.00 73.00 73.00 73.00 0 0 0 0.000000 73.00		0	0					
60.00 06000 LABORATORY 0 0 18, 109, 801 0.000000 60.00 60.01 06001 0NCOLOGY 0 0 0 7, 610, 268 0.000000 60.01 60.02 06002 RADI ATI ON ONCOLOGY 0 0 0 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 10, 645, 857 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 12, 558, 833 0.000000 69.01 69.01 06901 CARDI AC REHAB 0 0 0 0 0.000000 69.01 71.00 VOTOO MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 92,246,966 0.000000 72.00 73.00 07300 DRGS CHARGED TO PATI ENTS 0 0 0 92,246,966		0	0					
60.01 06001 0NCOLOGY 0 0 7, 610, 268 0.000000 60.01 60.02 06002 RADI ATI ON ONCOLOGY 0 0 0 0 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 10, 645, 857 0.000000 65.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 12, 558, 833 0.000000 69.00 69.01 06901 CARDI AC REHAB 0 0 0 12, 558, 833 0.000000 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 RUGS CHARGED TO PATI ENTS 0 0 0 0.000000 73.00 0000 09100 EMERGENCY 0 0 0 78, 28		0	0					
60.02 06002 RADI ATI ON ONCOLOGY 0 0 0 0 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0 0 0 8,785,684 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 10,645,857 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 12,558,833 0.000000 69.00 69.01 06901 CARDI AC REHAB 0 0 0 1,080,233 0.000000 69.01 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0.000000 73.00 90.00 09000 CLI NI C 0 0 0 73.00 90.00 91.00 92.246,966 0.000000 92.00 92.00 09200 DESERVATI ON BE		0	0				•	
65.00 06500 RESPIRATORY THERAPY 0 0 8,785,684 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 10,645,857 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 12,558,833 0.000000 69.00 69.01 06901 CARDI AC REHAB 0 0 0 1,080,233 0.000000 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0.000000 73.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 1,929,237 0.000000 90.00 90.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0.000000 92.01 92.01 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0.000000 92.0		0	0		0 7, 610, 268			
66.00 06600 PHYSI CAL THERAPY 0 0 10, 645, 857 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 12, 558, 833 0.000000 69.00 69.01 CARDI AC REHAB 0 0 0 1, 080, 233 0.000000 69.01 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0.000000 73.00 00 09000 CLI NI C 0 0 0 0.000000 73.00 01.00 09000 CLI NI C 0 0 0 73.00 90.00 91.00 92,246,966 0.000000 91.00 91.00 09000 CLI NI C 0 0 0 73.00 90.00 92.01 92.00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0 0		0	0		0 0			
69.00 06900 ELECTROCARDI OLOGY 0 0 12,558,833 0.000000 69.00 69.01 06901 CARDI AC REHAB 0 0 0 1,080,233 0.000000 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0.000000 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 92.00 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 90.000 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 90.00 73.00 0 09000 CLI NI C 0 0 0 1,929,237 0.000000 91.00 91.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0.000000 92.00		0	0					
69.01 06901 CARDI AC REHAB 0 0 1,080,233 0.000000 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 92.246,966 0.000000 73.00 0 09000 CLI NI C 0 0 0 1,929,237 0.000000 90.00 91.00 09100 EMERGENCY 0 0 78,281,413 0.000000 91.00 92.00 09200 (DSERVATI ON BEDS (IDI STI NCT PART) 0 0 0 0.000000 92.00 92.01 09201 (DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0.000000 92.01 92.01 09201 (DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0.000000 92.01 0		0	0		0 10, 645, 857	0.00000	66.00	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 92.246,966 0.000000 73.00 00 09000 CLI NI C 0 0 0 1,929,237 0.000000 90.00 90.00 09100 EMERGENCY 0 0 0 78,281,413 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0.000000 92.01 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0.000000 92.01 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0.000000 92.01 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0.000000 92.01 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0		0	0		0 12, 558, 833			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 92,246,966 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0,92,246,966 0.000000 73.00 90.00 09000 CLINIC 0 0 0 1,929,237 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 78,281,413 0.000000 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 8,193,383 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0.000000 92.01 07HER REI MBURSABLE COST CENTERS UTHER REI MBURSABLE COST CENTERS 95.00 95.00 95.00 95.00	69. 01 06901 CARDI AC REHAB	0	0		0 1, 080, 233	0.00000	69.01	
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 92,246,966 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 92,246,966 0.000000 90.00 90.00 09000 CLINIC 0 0 0 1,929,237 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 78,281,413 0.000000 91.00 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART) 0 0 8,193,383 0.000000 92.01 92.01 09201 DSERVATION BEDS (DISTINCT PART) 0 0 0 0.000000 92.01 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	0		0 0	0.00000	71.00	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 1,929,237 0.000000 90.00 91.00 09000 CLINIC 0 0 0 78,281,413 0.000000 91.00 92.00 09200 DBSERVATION BEDS (NON-DI STINCT PART) 0 0 0 8,193,383 0.000000 92.00 92.01 09201 DBSERVATION BEDS (DI STINCT PART) 0 0 0 0.000000 92.01 92.01 09201 OBSERVATION BEDS (DI STINCT PART) 0 0 0 0.000000 92.01 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.00000	72.00	
90.00 09000 CLINIC 0 0 1,929,237 0.00000 90.00 91.00 09100 EMERGENCY 0 0 0 78,281,413 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 8,193,383 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0.000000 92.00 92.01 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 92, 246, 966	0.00000	73.00	
91.00 09100 EMERGENCY 0 0 0 78, 281, 413 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 8, 193, 383 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.00 92.01 OTHER REI MBURSABLE COST CENTERS 0 0 0 0.000000 92.01 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00				-				
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 8, 193, 383 0.000000 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.00 92.00 92.01 01 0 0 0 0 0 0 0 92.01 92.01 01 0 0 0 0 0 0 0 92.01 92.01 01 0 0 0 0 0 0 0 0 92.01 01 0 0 0 0 0 0 0 92.01 02 0 0 0 0 0 0 0 0 0 92.01 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	90. 00 09000 CLINIC	0	0		0 1, 929, 237	0.000000	90.00	
92. 01 09201 0BSERVATION BEDS (DI STINCT PART) 0 0 0 0.000000 92. 01 0THER REI MBURSABLE COST CENTERS 95. 00 9500 AMBULANCE SERVICES 95. 00	91.00 09100 EMERGENCY	0	0		0 78, 281, 413	0.000000	91.00	
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 8, 193, 383	0.000000	92.00	
95. 00 09500 AMBULANCE SERVICES 95. 00	92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0.00000	92.01	
200.00 Total (lines 50 through 199) 0 0 0 427, 774, 064 200.00	95. 00 09500 AMBULANCE SERVI CES						95.00	
	200.00 Total (lines 50 through 199)	0	0		0 427, 774, 064		200.00	

Health Financial Systems	MARION GENERAL	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 10	
		Title	XVIII	Hospi tal PPS		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	12, 146, 687		0 19, 730, 987	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	934, 943		0 8, 089, 545	0	54.00
57.00 05700 CT SCAN	0. 000000	2, 371, 789		0 7, 608, 464	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	155, 924		0 922, 073	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 330, 930		0 2, 013, 043	0	59.00
60.00 06000 LABORATORY	0. 000000	1, 699, 007		0 1, 989, 224	0	60.00
60. 01 06001 ONCOLOGY	0. 000000	25, 354		0 3, 310, 555	0	60.01
60. 02 06002 RADIATION ONCOLOGY	0. 000000	0		0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 198, 096		0 1, 803, 357	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1,056,834		0 102, 962	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0, 000000	1,864,651		2, 466, 204	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	592		0 415, 104	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0,000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0,000000	3, 422, 438		40, 212, 912	0	73.00
OUTPATI ENT SERVI CE COST CENTERS						
90, 00 09000 CLINIC	0.000000	7, 805		0 740, 536	0	90.00
91. 00 09100 EMERGENCY	0, 000000	5, 385, 166		12, 728, 069	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0,000,100		0 1, 673, 897	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS	0.000000	0	<u> </u>	<u> </u>	<u>_</u>	,
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		31, 600, 216		0 103, 806, 932	0	200.00
	1 1	5., 555, 210	I		U U	

Health Fina	Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10								
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D			
					From 07/01/2018 To 06/30/2019		narod		
					10 00/30/2019	11/25/2019 10			
			Title	XVIII	Hospi tal	PPS	100 411		
				Charges		Costs			
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services			
	·	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)			
		From	Services (see	Servi ces	Services Not				
		Worksheet C,	inst.)	Subject To	Subject To				
		Part I, col.		Ded. & Coins.	Ded. & Coins.				
		9		(see inst.)	(see inst.)				
		1.00	2.00	3.00	4.00	5.00			
	LARY SERVICE COST CENTERS			1					
	O OPERATING ROOM	0. 169273			0 0	-/	50.00		
	D RECOVERY ROOM	0. 000000			0 0	0	51.00		
	D RADI OLOGY-DI AGNOSTI C	0. 256973			0 0	2, 078, 795			
	D CT SCAN	0. 047844			0 0	364, 019			
	D MAGNETIC RESONANCE I MAGI NG (MRI)	0. 278342			0 0	256, 652			
	D CARDI AC CATHETERI ZATI ON	0. 360348			0 0	725, 396	59.00		
	DLABORATORY	0. 638810				1, 270, 736			
	1 ONCOLOGY	0. 298231			0 0	987, 310	1		
	2 RADIATION ONCOLOGY	0. 000000			0 0	0	60.02		
	D RESPI RATORY THERAPY	0. 418047			0 0	753, 888	65.00		
	D PHYSI CAL THERAPY	0. 301213			0 0	31,013	1		
	D ELECTROCARDI OLOGY	0. 190379			0 0	469, 513	1		
	1 CARDI AC REHAB	0. 470144			0 0	195, 159	69.01		
	D MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	71.00		
	DIMPL. DEV. CHARGED TO PATIENTS	0.00000			0 0	0	72.00		
	D DRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS	0. 163052	40, 212, 912		0 7,086	6, 556, 796	73.00		
	DICLINIC	0. 732454	740, 536		0 0	542, 409	90.00		
		0. 143828			0 0	1, 830, 653	90.00		
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 434303			0 0	726, 978			
	1 OBSERVATION BEDS (NON-DISTINCT PART)	0. 434303			0 0	120, 978	92.00		
	R REIMBURSABLE COST CENTERS	0.00000	0		0 0	0	72.01		
	D AMBULANCE SERVICES	0. 520503			0		95.00		
200.00	Subtotal (see instructions)	0. 320303	103, 806, 932			20, 129, 240			
200.00	Less PBP Clinic Lab. Services-Program		100,000, 932		0 7,000		200.00		
201.00	Only Charges						201.00		
202.00	Net Charges (line 200 - line 201)		103, 806, 932	13	6 7, 086	20, 129, 240	202.00		

Heal th	Financial Systems	MARION GENER	AL HOSPITAL		In Lie	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		D VACCINE COST	Provi der	CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019		epared: 0:38 am	
			Ti	tle XVIII	Hospi tal	PPS		
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Reimbursed	Reimburse					
		Servi ces	Services No					
		Subject To	Subject To					
		Ded. & Coins.						
		(see inst.)	(see inst.					
		6.00	7.00					
50.00	ANCI LLARY SERVI CE COST CENTERS							
	05000 OPERATING ROOM	0		0			50.00	
	05100 RECOVERY ROOM	0		0			51.00	
	05400 RADI OLOGY-DI AGNOSTI C	0		0			54.00	
	05700 CT SCAN	0		0			57.00	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0			58.00	
	05900 CARDI AC CATHETERI ZATI ON	0		0			59.00	
	06000 LABORATORY	87		0			60.00	
	06001 ONCOLOGY 06002 RADIATION ONCOLOGY	0		0			60. 01 60. 02	
	06500 RESPIRATORY THERAPY	0		0			60.02	
	06600 PHYSI CAL THERAPY	0		0			66.00	
	06900 ELECTROCARDI OLOGY	0		0			69.00	
	06901 CARDI AC REHAB	0		0			69.00	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0			71.00	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0			72.00	
	07300 DRUGS CHARGED TO PATIENTS	0	1, 1	U			73.00	
73.00	OUTPATIENT SERVICE COST CENTERS	0	Ι,	100			/3.00	
90.00	09000 CLINIC	0		0			90.00	
	09100 EMERGENCY	0		0			91.00	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0			92.00	
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0		0			92.00	
72.01	OTHER REIMBURSABLE COST CENTERS	0	I	0			72.01	
95.00	09500 AMBULANCE SERVICES	0					95.00	
200.00		87		55			200.00	
200.00		0	' <i>'</i>				201.00	
201.00	Only Charges							
202.00		87	1, 1	55			202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CN: 15-011 Component CN: 15-011 To 06/30/2019 Period Cr Patr II Date/Time Prepared: 11/22/2019 10: 38 em Provider - 11/22/2019 10: 38 em Provider - 11/22/2019 10: 38 em Provider - IRF Period Cr Port II Coll Charges (col. 1 + col. 2) Period Cr Port II Coll Charges (col. 1 + col. 2) Period Cr Port II Coll Charges (col. 1 + col. 2) Period Cost Coll Charges (col. 1 + col. 2) Deriod Cost Coll Charges (col. 1 + coll Charges (col. 1 + coll Charges (col. 1 + coll Charges (col. 1 + coll Charges (coll C	Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
AnciLLARY SERVICE COST CENTERS Component CON: 15-T011 To 06/30/2019 Date/Time Prepared: 1/25/2019 Date/Time Prepared: 1/25/2019 AnciLLARY SERVICE COST CENTERS Capital Related Cost: (from Wkst. B, Part II, col. 26) Total Charges (col. 1 + col. 26) Total Charges (col. 1 + col. 26) Total Charges (col. 1 + col. 26) Capital Charges (col. 1 + col. 26) Capital Charges (col. 1 + col. 26) Capital (col. 27) Capi	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C				
Cost Center Description Capital Related Cost (from Wkst. Col. 26) Total Charges (from Wkst. Col. 2) Ratio of Cost to Charges (col. 1 + col. 2) Inpatient Program Col 2 (col. 1 + col. 2) Capital Costs (col um 3 x col um 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERATI NG ROM 2.068,446 108,425,123 0.019077 34,129 651 50.00 51.00 05100 RECOVERY ROOM 0 1.01 0 0.000000 0 51.00 54.00 05400 CAPEART IN GROM 1.02,447 3.809,573 0.032564 7.999 258 58.00 59.00 05000 CARDIA CATHERI ZATI 0N 311,551 8.103,862 0.038444 2.278 88 59.00 60.01 06000 LABORATORY 857,947 18,109,801 0.0447375 73.625 3.488 60.01 60.01 06000 PHYSI CAL THERAPY 106,641 0.645,857 91.240 3.162 66.00 60.00 0.0000000 0 0 0.0000000 0 0 0.0000000 <			Component				narod
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91.00 09100 EMERGENCY 862,760 78,281,413 0.011021 93,652 1,032 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 8,193,383 0.000000 0 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 00 92.00 92.01 0THER REIMBURSABLE COST CENTERS 0 0 0.000000 0 92.01 95.00 09500 AMBULANCE SERVICES 0 0 95.00 95.00		169, 387	1, 929, 237	0. 08780	88 00	8	90.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 8, 193, 383 0.000000 0 92.00 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.00 92.00 01 01 05 01 0 0 0 0 92.01 01 01 01 01 01 01 01 92.01 01 01 01 01 01 01 01 92.01 01 01 01 01 01 01 01 92.01 01 01 01 01 01 01 01 92.01 02 01 01 01 01 01 01 92.01 03 00 09500 AMBULANCE SERVICES 01 01 95.00	91.00 09100 EMERGENCY			0. 01102	93, 652	1,032	91.00
92.01 09201 0BSERVATION BEDS (DI STINCT PART) 0 0 0.000000 0 92.01 0THER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0.00000			92.00
95.00 09500 AMBULANCE SERVICES 95.00		0			0 0	0	92.01
95.00 09500 AMBULANCE SERVICES 95.00					·		
200.00 Total (lines 50 through 199) 7,067,744 427,774,064 3,061,653 35,999 200.00							95.00
	200.00 Total (lines 50 through 199)	7,067,744	427, 774, 064		3, 061, 653	35, 999	200.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provider C	CN: 15-0011	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T011	From 07/01/2018 To 06/30/2019	Part IV Date/Time Pre	nared
		component	CCN. 13-1011	10 00/ 30/ 2017	11/25/2019 10	:38 am
		Title	× XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments 2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0				0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	54.00
57. 00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 ONCOLOGY	0	0		0 0	0	60.01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0	60.02
65.00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 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	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	I	0 0	0	92.01
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES			1			95.00
200.00 Total (lines 50 through 199)	0	0		0 0	_	95.00 200.00
200.00 TOTAL (THES SO THEOUGH 199)	1 0	1 0	1	0	0	1200. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 07/01/2018 To 06/30/2019		nared
		•			11/25/2019 10	:38 am
		Title	e XVIII	Subprovider -	PPS	
				I RF	-	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal Educati on	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	C, Part I, col. 8)	(col. 5 ÷ col. 7)	
	COST	4)	and 4)	CUI. 0)	COI. 7)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 108, 425, 123	0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 34, 724, 588	0.00000	
57.00 05700 CT SCAN	0	0		0 33, 809, 573		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 3, 269, 243		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 8, 103, 862		•
60. 00 06000 LABORATORY	0	0		0 18, 109, 801	0. 000000	
60. 01 06001 0NC0L0GY	0	0		0 7, 610, 268		
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0. 000000	
65.00 06500 RESPI RATORY THERAPY	0	0		0 8, 785, 684	0.00000	
66.00 06600 PHYSI CAL THERAPY	0	0		0 10, 645, 857		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 12, 558, 833		
69. 01 06901 CARDI AC REHAB	0	0		0 1, 080, 233		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0 0 0 0	0.00000	
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0		0 92, 246, 966	0. 000000	73.00
90. 00 09000 CLINIC	0	0		0 1, 929, 237	0. 000000	90.00
91. 00 109000 EMERGENCY	0			0 78, 281, 413		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 8, 193, 383	0. 000000	
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT FART)	0			0 0, 175, 505	0.000000	
OTHER REIMBURSABLE COST CENTERS	0	0	1	0	0.00000	12.01
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 427, 774, 064		200.00

Health Financial Systems	MARI ON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component (From 07/01/2018 To 06/30/2019	Part IV Date/Time Pre	narod
		component v	JCN. 15-1011	10 00/30/2019	11/25/2019 10	:38 am
		Title	XVIII	Subprovider -	PPS	
				IRF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS				-	_	
50. 00 05000 OPERATING ROOM	0. 000000	34, 129		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	39, 695		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	64, 633		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	7, 999		0 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 278		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	73, 625		0 0	0	60.00
60. 01 06001 0NC0L0GY	0. 000000	592		0 0	0	60.01
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000	0		0 0	0	60. 02
65. 00 06500 RESPI RATORY THERAPY	0. 000000	91, 240		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 208, 644		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	54, 485		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	390, 593		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0. 000000	88		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	93, 652		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		3, 061, 653		0 0	0	200.00

	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2018 To 06/30/2019	Date/Time Pre	
		Title XVIII	Hospi tal	11/25/2019 10 PPS	: 38
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		16, 907	1 1.
00	Inpatient days (including private room days and sming bed day Inpatient days (including private room days, excluding swing			16, 907	
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation l	bed days)		13, 514	4
00	Total swing-bed SNF type inpatient days (including private re		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private re	oom days) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	oom days) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)			Ũ	
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	5, 955	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	onlv (including private	room davs)	0	10
	through December 31 of the cost reporting period (see instru	ctions)	5 .		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
00	through December 31 of the cost reporting period			0	1.0
. 00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
	Medically necessary private room days applicable to the Prog			0	
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		I	0	16
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service			0.00	19
	reporting period	0			
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ns)		17, 731, 170	21
. 00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		17, 731, 170	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		liar goo)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35)	2		0	
	General inpatient routine service cost net of swing-bed cost		ifferential (line	17, 731, 170	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
				1, 048. 75	1 38
	Adjusted general inpatient routine service cost per diem (see		1		
9.00	Program general inpatient routine service cost per diem (ser Medically necessary private room cost applicable to the Program	e 38)		6, 245, 306 0	39

	Financial Systems	MARI ON GENERA		011 15 0011		u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	eriod: rom 07/01/2018 o 06/30/2019	Worksheet D-1 Date/Time Pre 11/25/2019 10	pared:
			Title	e XVIII	Hospi tal	PPS	<u>. 30 am</u>
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
43. 00 44. 00 45. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	5, 293, 276	3, 749	1, 411. 92	1, 175	1, 659, 006	44.00 45.00
46.00 47.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00 47.00
	Cost Center Description					4.00	
48.00	Program inpatient ancillary service cost (Wk		Lino 200)			1.00 6,538,489	48.00
48.00	Total Program inpatient costs (sum of lines			ons)		14, 442, 801	•
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	1, 189, 919	50.00
51.00	III) Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, si	um of Parts II	602, 874	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)	• · ·			1, 792, 793	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-ph	ysician anesth	etist, and	12, 650, 008	•
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)				50)	0	•
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (line 56 minus i	line 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the		
60.00	market basket Lesser of lines 53/54 or 55 from prior year					0. 00 0	•
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61.00
62.00 63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(lino 14 v l	ino 25)			72.00
73.00	Total Program general inpatient routine serv	0	•				74.00
75.00	Capital -related cost allocated to inpatient 26, line 45)	•		·	art II, column		75.00
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 minu	s line 77)					78.00
79.00	Aggregate charges to beneficiaries for exces	x 1		,			79.00
80.00	Total Program routine service costs for comp		ost limitatio	n (line 78 min	us line 79)		80.00
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.00 82.00
82.00	Reasonable inpatient routine service cost film tation (i		· .				83.00
84.00	Program inpatient ancillary services (see in		-				84.00
85.00	Utilization review - physician compensation	•					85.00
86.00	Total Program inpatient operating costs (sum		rough 85)				86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					3, 393	87.00
88.00	Adjusted general inpatient routine cost per		line 2)			1, 048. 75	•
	Observation bed cost (line 87 x line 88) (se	•				3, 558, 409	

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2018	Worksheet D-1	
				To 06/30/2019		pared: :38 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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, 792, 889	17, 731, 170	0. 15751	3 3, 558, 409	560, 496	90.00
91.00 Nursing School cost	0	17, 731, 170	0.00000	0 3, 558, 409	0	91.00
92.00 Allied health cost	0	17, 731, 170	0.00000	0 3, 558, 409	0	92.00
93.00 All other Medical Education	0	17, 731, 170	0.00000	3, 558, 409	0	93.00

	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0011	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T011	From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 10	pare
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed day			2, 821	
00	Inpatient days (including private room days, excluding swing			2, 821	
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.
~~	do not complete this line.			2,021	
00 00	Semi-private room days (excluding swing-bed and observation H Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	2, 821 0	
00	reporting period	colli days) thi odgit becellib		0	J J.
00	Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	com days) ar ter becomber		0	0.
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.
	reporting period	5 / 5			
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 🗄	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	2, 091	9
	newborn days)			-	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10.
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of			0	1 1 1
. 00	December 31 of the cost reporting period (if calendar year,		oom days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room dave)	0	12
. 00	through December 31 of the cost reporting period	TX only (Therdaring priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendary				
. 00	Medically necessary private room days applicable to the Prog			0	14
. 00	Total nursery days (title V or XIX only)		3 ,	0	15
. 00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 (of the cost	0.00	17
	reporting period		11	0.00	1
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces aiter becenber 31 01	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
. 00	reporting period	es through becomber of o		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction	ns)		3, 701, 486	21
. 00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
- 00	7 x line 19)			0	0.5
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (Tine 8	0	25
5.00	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 701, 486	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		I	0,101,100	1 - 1
3. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)		-	0	
. 00	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi		culons)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35)	and private room cost d	fforontial (line	0 3 701 486	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	incicittai (IINe	3, 701, 486	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
		JUSTMENTS			1
	PRUGRAW INFALLENT VEEKATING UUST DEEUKE PASS TORUUGO UUST AU				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 312, 12	38
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	e instructions)		1, 312. 12 2, 743, 643	
0. 00	Adjusted general inpatient routine service cost per diem (see	e instructions) e 38)			39

Health Financial	Systems IPATIENT OPERATING COST	MARION GENERAL		CN: 15-0011	In Lie Period:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-T011	From 07/01/2018 To 06/30/2019		epared:
			Title	e XVIII	Subprovider - IRF	PPS	<u>. 50 ai</u>
Cost	Center Description	Total I npati ent Cost	Total I npati ent Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42 00 NURSERV (†	itle V & XIX only)	1.00	2.00	3.00 0.	4.00	5.00	42.0
	Care Type Inpatient Hospital Units	<u> </u>		0.	00 0		1 42.0
46.00 SURGI CAL I		0	C	0.	00 0	0	43.00 44.00 45.00 46.00 47.00
Cost	Center Description					1.00	
48.00 Program in	patient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1.00 860,335	48.0
49.00 Total Prog	ram inpatient costs (sum of lines GH COST ADJUSTMENTS			ons)		3, 603, 978	
50.00 Pass throu	gh costs applicable to Program inp	atient routine s	ervices (fro	m Wkst. D, sı	um of Parts I and	438, 985	50.0
	gh costs applicable to Program inp	atient ancillary	services (f	rom Wkst. D,	sum of Parts II	35, 999	51.0
and IV) 52.00 Total Prog	ram excludable cost (sum of lines	50 and 51)				474, 984	52.0
53.00 Total Prog medical ed	Tam inpatient operating cost exclu ucation costs (line 49 minus line INT AND LIMIT COMPUTATION	ding capital rel	ated, non-ph	ysician anest	hetist, and	3, 128, 994	
54.00 Program di	scharges					0	
	unt per discharge unt (line 54 x line 55)					0.00	
	between adjusted inpatient operat	ing cost and tar	get amount (line 56 minus	s line 53)	0	
	ent (see instructions) lines 53/54 or 55 from the cost re	porting period e	ending 1996,	updated and o	compounded by the	0.00	58.0 59.0
market bas			-			0.00	
61.00 If line 53 which oper-	lines 53/54 or 55 from prior year /54 is less than the lower of line ating costs (line 53) are less tha ne 56), otherwise enter zero (see	s 55, 59 or 60 e n expected costs	enter the les	ser of 50% of	f the amount by	0.00	
62.00 Relief pay 63.00 Allowable	Inpatient cost plus incentive paym PATIENT ROUTINE SWING BED COST		tions)			000	
64.00 Medicare s	wing-bed SNF inpatient routine cos ns)(title XVIII only)	ts through Decem	ber 31 of th	e cost report	ing period (See	0	64.0
65.00 Medicare s	wing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reportir	ng period (See	0	65.0
66.00 Total Medi	ns)(title XVIII only) care swing-bed SNF inpatient routi	ne costs (line 6	4 plus line	65)(title XVI	II only). For	0	66.0
	nstructions) XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	reporting period	0	67.0
(line 12 x 68.00 Title V or	line 19) XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost rep	porting period	0	68.0
(line 13 x 69.00 Total title	line 20) e V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + lin	e 68)		0	69.0
	SKILLED NURSING FACILITY, OTHER N				- \	1	
	rsing facility/other nursing facil eneral inpatient routine service c	5		•	()		70.0
, , , , , , , , , , , , , , , , , , , ,	utine service cost (line 9 x line						72.0
	necessary private room cost applic	0	•				73.0
U U U	ram general inpatient routine serv lated cost allocated to inpatient	•			Part II, column		74.0 75.0
26, line 4 76.00 Per diem c	5) apital-related costs (line 75 ÷ li	ne 2)					76.0
77.00 Program ca	pital-related costs (line 9 x line	76)					77.0
	routine service cost (line 74 minu charges to bopoficiaries for exces		ovidor rocor	de)			78.0
55 5	charges to beneficiaries for exces ram routine service costs for comp				nus line 79)		80.0
0	routine service cost per diem limi			(/ o mi			81.0
	routine service cost limitation (I	,					82.0
	inpatient routine service costs (;)				83.0
-	patient ancillary services (see in n review - physician compensation		s)				84.0 85.0
	ram inpatient operating costs (sum	•	· ·				86.0
PART IV - (COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
	rvation bed days (see instructions					0	
, , , , , , , , , , , , , , , , , , , ,	eneral inpatient routine cost per n bed cost (line 87 x line 88) (se	•	iine ∠)				88. 0 89. 0
or of longer value						1 0	1 0 7.

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2018	Worksheet D-1	
		Component (CCN: 15-T011	To 06/30/2019		pared: :38 am
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	592, 228	3, 701, 486	0. 15999	97 0	0	90.00
91.00 Nursing School cost	0	3, 701, 486	0.0000	0 0	0	91.00
92.00 Allied health cost	0	3, 701, 486	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 701, 486	0.00000	0 0	0	93.00

)MPUT	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	of Form CMS-2 Worksheet D-1 Date/Time Pre 11/25/2019 10	pare
	Cast Canton Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		16, 907	1.
00	Inpatient days (including private room days, excluding swing-			16, 907	2.
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation b	ped davs)		13, 514	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.
00	reporting period Total swing-bed SNF type inpatient days (including private ro	and dave) after December	21 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	Julii days) arter beceniber	ST OF THE COST	0	0
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.
00	reporting period	m dave) ofter December	21 of the east	0	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after becember	31 OF THE COST	0	8
00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	707	9
00	newborn days)	anly (including private	room dave)	0	10
). 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e		+	0	1.2
2.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including priva	te room days)	0	12
8.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y			0	
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0 1, 910	14
	Nursery days (title V or XIX only)				16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 21 a	f the cost	0.00	10
. 00	reporting period	es through becember 51 0	T the cost	0.00	
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction)		17, 731, 170	21
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		22
	5 x line 17)				
8.00	Swing-bed cost applicable to SNF type services after December x line 18)	- 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
	7 x line 19)		0		
5. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
b. 00	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		17, 731, 170	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had a	harges)	0	28
	Private room charges (excluding swing-bed charges)	ed and observation bed c	nai ges)	0	20
	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	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	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line $34 \times 1i$	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 17, 731, 170	36
. 00	27 minus line 36)			17, 751, 170	''
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		Г	1 040 75	38
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 048. 75 741, 466	
	Medically necessary private room cost applicable to the Progr			0	40
	Total Program general inpatient routine service cost (line 39			741, 466	1 4 1

	Financial Systems	MARION GENERA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		eriod: rom 07/01/2018 o 06/30/2019	Date/Time Pre	pared:
				e XIX	Hospi tal	11/25/2019 10 Cost	:38 am
	Cost Center Description	Total Inpatient Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	<u>1.00</u> 1,737,011	2.00 1,910	<u>3.00</u> 909.43	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	1,737,011	1, 710	////.43	0	0	42.00
43.00 44.00 45.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T	5, 293, 276	3, 749	1, 411. 92	0	0	43.00 44.00 45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			425, 968	48.00
49.00	Total Program inpatient costs (sum of lines		· · · ·	ons)		1, 167, 434	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51.00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	atient ancilla	ry services (f	rom Wkst. D, su	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines					0	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-ph	ysician anesthe	etist, and	0	53.00
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus I	line 53)	0	
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1996	undated and cor	mounded by the	0.00	
57.00	market basket	por tring period	ending 1990,		ipounded by the	0.00	37.00
60.00 61.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less tha	s 55, 59 or 60	enter the les	ser of 50% of ⁻		0.00 0	
62.00	 which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 						62.00
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			a cost reporti	an partial (Saa	0	
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	-				0	
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)		·		57	0	
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	0			0.1		
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)				rting period	0	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY		0	
70.00 71.00	Skilled nursing facility/other nursing facil	2		• •			70.00
71.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		III + IINe	∠)			71.00 72.00
73.00	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)			74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)		e costs (from	Worksheet B, Pa	art II, column		75.00
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 minu						78.00
79.00	Aggregate charges to beneficiaries for exces		orovider recor	ds)			79.00
80.00	Total Program routine service costs for comp		cost limitatio	n (line 78 minu	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi		1)				81.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00 83.00
84.00	Program inpatient ancillary services (see in		/				84.00
85.00	Utilization review - physician compensation		ons)				85.00
86.00	Total Program inpatient operating costs (sum		nrough 85)				86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions					3, 393	87.00
88.00	Adjusted general inpatient routine cost per	•	+ line 2)			1, 048. 75	
	Observation bed cost (line 87 x line 88) (se	•				3, 558, 409	

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2018	Worksheet D-1	
				To 06/30/2019		pared: :38 am_
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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, 792, 889	17, 731, 170	0. 15751	3 3, 558, 409	560, 496	90.00
91.00 Nursing School cost	0	17, 731, 170	0.00000	0 3, 558, 409	0	91.00
92.00 Allied health cost	0	17, 731, 170	0.00000	0 3, 558, 409	0	92.00
93.00 All other Medical Education	0	17, 731, 170	0.00000	0 3, 558, 409	0	93.00

MPLIT	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0011	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T011	From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 10	pared
		Title XIX	Subprovider -	Cost	. 30 6
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			2, 821	
00	Inpatient days (including private room days, excluding swing	5,		2, 821	2.
00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	had days)		2, 821	4.
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	2, 021	
00	reporting period			0	0.
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)	•			
00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7.
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (oveludin	a swing bod and	174	9
50	newborn days)		g swing-bed and	174	2.
00	Swing-bed SNF type inpatient days applicable to title XVIII	onlv (including private	room davs)	0	10
	through December 31 of the cost reporting period (see instru				
00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days) after	0	11
	December 31 of the cost reporting period (if calendar year,				
. 00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12
00	through December 31 of the cost reporting period				10
00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
00	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)	Tall (excluding swing-bed	uays)	1, 910	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		I		
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17
~ ~	reporting period				
00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	0.00	19
. 00	reporting period	es thiough becember 51 0		0.00	'
00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction			3, 701, 486	21
. 00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22
~~	5 x line 17)				
00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decemb	or 21 of the cost report	ing pariod (line	0	24
. 00	7 x line 19)	er 51 bi the cost report	ing period (inte	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)				
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 701, 486	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		````		
. 00 . 00	General inpatient routine service charges (excluding swing-b	ed and observation bed c	narges)	0	
. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ctions)	0.00	34
00	Average per diem private room cost differential (line 34 x l	ine 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	3, 701, 486	37
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	IUSTMENTS			-
				1, 312. 12	38
. 00					
	Adjusted general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x line			228, 309	
0. 00		e 38)			39.

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	MARI ON GENERAL		CN: 15-0011	Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-T011	From 07/01/2018 To 06/30/2019		epared:
		Ti tl	e XIX	Subprovider -	Cost	<u></u>
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Un	0 its	0	0.0	0 0	0	42.00
43. 00 I NTENSI VE CARE UNI T	0	C	0. (0 00	0	
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT						44.00
46. 00 SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.0
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost					10, 430	
49.00 Total Program inpatient costs (sum of lir PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(see instructi	ons)		238, 739	49.00
50.00 Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
<pre>111) 51.00 Pass through costs applicable to Program</pre>	innationt ancillar	v sorvicos (f	rom Wkst D	sum of Parts II	0	51.00
and IV)		y services (i	TOIN WKSt. D,	Sum of Parts II		51.00
52.00 Total Program excludable cost (sum of lir					0	
53.00 Total Program inpatient operating cost ex medical education costs (line 49 minus li		Tated, non-ph	ysician anest	netist, and	C	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges 55.00 Target amount per discharge					0.00	
56.00 Target amount (line 54 x line 55)					0	
57.00 Difference between adjusted inpatient ope 58.00 Bonus payment (see instructions)	erating cost and ta	rget amount (line 56 minus	line 53)		
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996,	updated and c	ompounded by the	-	
market basket		0		. ,		
60.00 Lesser of lines 53/54 or 55 from prior ye 61.00 If line 53/54 is less than the lower of l					0.00	
which operating costs (line 53) are less	than expected cost					
amount (line 56), otherwise enter zero (s 62.00 Relief payment (see instructions)	ee instructions)				l o	62.00
63.00 Allowable Inpatient cost plus incentive p	ayment (see instru	ctions)			0	
64.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine	costs through Doco	mbor 21 of th	o cost roport	ing part of (Saa	C	64.00
instructions) (title XVIII only)	costs through bece		e cost report	ring period (See		04.00
65.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decemb	er 31 of the	cost reportir	g period (See	0	65.00
66.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient rou	ting costs through	December 21	of the cost r	concreting portiod	0	67.00
(line 12 x line 19)	time costs through	December 31	of the cost i	eporting period		07.00
68.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	itine costs after D	ecember 31 of	the cost rep	orting period	0	68.00
69.00 Total title V or XIX swing-bed NF inpatie	ent routine costs (line 67 + lin	e 68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHE 70.00 Skilled nursing facility/other nursing fa						70.00
71.00 Adjusted general inpatient routine servic)		71.00
72.00 Program routine service cost (line 9 x li						72.0
73.00 Medically necessary private room cost app 74.00 Total Program general inpatient routine s	5	•	,			73.0
75.00 Capital-related cost allocated to inpatie				Part II, column		75.0
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷	line 2)					76.0
77.00 Program capital -related costs (line 9 x l	,					77.0
78.00 Inpatient routine service cost (line 74 m 79.00 Aggregate charges to beneficiaries for ex	,	rovidor rocor	de)			78.0
30.00 Total Program routine service costs for c				nus line 79)		80.0
31.00 Inpatient routine service cost per diem I	imitation			<i>,</i>		81.0
82.00 Inpatient routine service cost limitation 83.00 Reasonable inpatient routine service cost		· .				82.0
84.00 Program inpatient ancillary services (see	•	-,				84.0
85.00 Utilization review - physician compensati						85.0
86.00 Total Program inpatient operating costs (PART IV - COMPUTATION OF OBSERVATION BED		rougn 85)				86.00
87.00 Total observation bed days (see instructi	ons)				0	
88.00 Adjusted general inpatient routine cost p89.00 Observation bed cost (line 87 x line 88)	•	iine 2)			0.00	88.00 89.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2018	Worksheet D-1	
		Component (CCN: 15-T011	To 06/30/2019		pared: :38 am
		Ti tl	e XIX	Subprovider -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	592, 228	3, 701, 486	0. 15999	97 0	0	90.00
91.00 Nursing School cost	0	3, 701, 486	0.0000	0 0	0	91.00
92.00 Allied health cost	0	3, 701, 486	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 701, 486	0. 00000	0 0	0	93.00

Heal th Financial Systems MARION GENERAL		011 15 0011		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Period: From 07/01/2018	Worksheet D-3	3
			To 06/30/2019		narod
			10 00/ 30/ 2017	11/25/2019 10): 38 ar
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	st Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1	
30. 00 03000 ADULTS & PEDIATRICS			7, 487, 070		30.0
31. 00 03100 I NTENSI VE CARE UNI T			2, 548, 137		31.0
40. 00 04000 SUBPROVI DER – I PF			0		40.0
41. 00 04100 SUBPROVI DER - I RF			0		41.0
42. 00 04200 SUBPROVI DER			0		42.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 1692	73 12, 146, 687	2, 056, 106	50.0
51.00 05100 RECOVERY ROOM		0.0000	00 0	0	51.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2569	73 934, 943	240, 255	54.0
57.00 05700 CT SCAN		0.0478	44 2, 371, 789	113, 476	57.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2783	42 155, 924	43, 400	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.3603	48 1, 330, 930	479, 598	59.0
60. 00 06000 LABORATORY		0. 6388	10 1, 699, 007		
60. 01 06001 ONCOLOGY		0. 2982	31 25, 354	7, 561	60.0
60. 02 06002 RADI ATI ON ONCOLOGY		0.0000			
65. 00 06500 RESPIRATORY THERAPY		0. 4180			
66. 00 06600 PHYSI CAL THERAPY		0. 3012			
69. 00 06900 ELECTROCARDI OLOGY		0. 1903			
69. 01 06901 CARDI AC REHAB		0. 4701			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.0000			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		-	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1630		-	
OUTPATIENT SERVICE COST CENTERS		0.1030	52 5, 422, 430	556,055	13.0
90. 00 09000 CLINIC		0. 7324	54 7,805	5, 717	90.0
91. 00 09100 EMERGENCY		0. 1438			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1438	28 5, 385, 166 03 0		
		0. 4343			
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0.0000		0	92.0
95.00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			31, 600, 216	6, 538, 489	
	an (line (1)				
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (ine of)		0		201.0
202.00 Net charges (line 200 minus line 201)		I	31, 600, 216	1	202.0

Health Financial Systems MARION GENERAL H	OSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T011	From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 10	
	Title	e XVIII	Subprovider -	PPS	
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			2, 731, 667		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			-		43.00
ANCI LLARY SERVI CE COST CENTERS		•			
50. 00 05000 OPERATI NG ROOM		0. 1692	73 34, 129	5, 777	50.00
51.00 05100 RECOVERY ROOM		0.0000	0 00	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2569	73 39, 695	10, 201	54.00
57.00 05700 CT SCAN		0.0478	44 64, 633	3, 092	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2783		2, 226	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3603		821	
60. 00 06000 LABORATORY		0. 6388		47,032	60.00
60. 01 06001 ONCOLOGY		0. 2982		177	
60. 02 06002 RADIATION ONCOLOGY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 4180		38, 143	
66.00 06600 PHYSI CAL THERAPY		0. 3012		665, 272	
69. 00 06900 ELECTROCARDI OLOGY		0. 1903		10, 373	
69. 01 06901 CARDI AC REHAB		0.4701		0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.0000		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0.1630	52 390, 593	63, 687	73.00
90. 00 09000 CLINIC		0.7324	54 88	64	90.00
91. 00 09100 EMERGENCY		0. 1438		13, 470	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4343		13,470	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000		0	
OTHER REIMBURSABLE COST CENTERS		010000			12101
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 061, 653	860, 335	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			3, 061, 653		202.00

Health Financial Systems MARION GENER/		CNL 1E 0011		u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Period: From 07/01/2018	Worksheet D-3	6
			To 06/30/2019	Date/Time Pre	enared
			10 00/00/2017	11/25/2019 10): 38 ar
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
'		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 & PEDIATRICS			944, 198		30.0
31. 00 03100 I NTENSI VE CARE UNI T			211, 768		31.0
40. 00 04000 SUBPROVIDER - IPF			0		40.0
41. 00 04100 SUBPROVIDER - IRF			0		41.0
42. 00 04200 SUBPROVI DER			0		42.0
43. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1692	73 1, 103, 887	186, 858	50.0
51.00 05100 RECOVERY ROOM		0.0000	00 0	0	51.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2569	73 71, 695	18, 424	54.0
57. 00 05700 CT SCAN		0.0478		6, 877	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2783		1, 335	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3603		1,674	
50. 00 06000 LABORATORY		0.6388		78, 516	
50. 01 06001 0NC0L0GY		0. 2982		148	
50. 02 06002 RADI ATI ON ONCOLOGY		0.0000		0	
55. 00 06500 RESPI RATORY THERAPY		0. 4180		20, 547	
66. 00 06600 PHYSI CAL THERAPY		0. 3012		10, 735	
59. 00 06900 ELECTROCARDI OLOGY		0. 3012		19, 755	
59. 01 06901 CARDI AC REHAB		0. 4701		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1630	52 213, 391	34, 794	73.0
OUTPATIENT SERVICE COST CENTERS		0 7004	54		
20. 00 09000 CLINIC		0.7324		0	
01.00 09100 EMERGENCY		0. 1438		46, 305	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4343		0	1
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	00 0	0	92.0
OTHER REI MBURSABLE COST CENTERS		1			0.5 0
95.00 09500 AMBULANCE SERVICES			0 474 050	405 0/0	95.0
Total (sum of lines 50 through 94 and 96 through 98)			2, 176, 052	425, 968	
201.00 Less PBP Clinic Laboratory Services-Program only char	rges (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			2, 176, 052		202.0

Health Financial Systems MARION GENERA				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T011	From 07/01/2018 To 06/30/2019	Date/Time Pre	nared
	component	0011. 10 1011	10 00/30/2017	11/25/2019 10):38 am
	Ti tl	e XIX	Subprovider -	Cost	
			I RF		
Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			34, 479		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1692		0	
51.00 05100 RECOVERY ROOM		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2569			
57. 00 05700 CT SCAN		0.0478		49	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2783		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3603		0	
60. 00 06000 LABORATORY		0. 6388		293	
60. 01 06001 0NC0L0GY		0. 2982		0	
60. 02 06002 RADI ATI ON ONCOLOGY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 4180		1, 236	
66. 00 06600 PHYSI CAL THERAPY		0. 3012			
69. 00 06900 ELECTROCARDI OLOGY		0. 1903		46	
69. 01 06901 CARDI AC REHAB		0. 4701		0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.0000		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1630	52 3, 072	501	73.00
OUTPATIENT SERVICE COST CENTERS				-	
90. 00 09000 CLINIC		0.7324		0	
91.00 09100 EMERGENCY		0. 1438		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4343		0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	00 0	0	92.01
OTHER REI MBURSABLE COST CENTERS		1			05.65
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			35, 403	10, 430	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	35, 403		202.00

	Financial Systems MARION GENERAL ATION OF REI MBURSEMENT SETTLEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2018	u of Form CMS-2 Worksheet E Part A	2002-10
			To 06/30/2019	Date/Time Pre 11/25/2019 10 PPS	
		Title XVIII	Hospi tal		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	0 3, 508, 863	
1. 02	instructions) DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	10, 128, 960	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			96, 288 0	2.00 2.01
2.02 3.00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	i ons)		0 0	2.02 3.00
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment			96.52	4.00
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)				5.00
6.00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0. 00 0. 00	7.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	e ACA. If the cost	0.00	8.01
8. 02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	ots from a closed teach	ning hospital	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir instructions)	nes (8, 8,01 and 8,02)	(see	0.00	9.00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	rent year from your reco	ords		10.00 11.00
12.00	Current year allowable FTE (see instructions)				12.00
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	ear ended on or after Se	ptember 30, 1997,		13.00 14.00
15.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0 00	15.00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital clo	osure			17.00
	Adjusted rolling average FTE count				18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
22.00	IME payment adjustment (see instructions)			0.000000	
22.00	IME payment adjustment - Managed Care (see instructions)			0	
23.00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105		23.00
24.00	(f)(1)(iv)(C) IME FTE Resident Count Over Cap (see instructions)	·			24.00
25.00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or lin	ne 24 (see	0.00	25.00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	
28. 01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
30 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	ictions)	<u>Б</u> 1Б	30.00
		attent days (see instru			30.00
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31				31.00
32.00	Allowable disproportionate share percentage (see instructions			15.19	
	Disproportionate share adjustment (see instructions)	· /		517, 896	

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Date/Time Pre	
		Title XVIII	Hospi tal	11/25/2019 10 PPS	: 38 2
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		-		
5.00	Total uncompensated care amount (see instructions)			8, 272, 872, 447	
5.01	Factor 3 (see instructions)		0. 000205554		
5.02	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (s	ee 1, 390, 921	2, 292, 076	35.0
- 00	instructions)		250 500	4 744 047	0.5
5.03 6.00	Pro rata share of the hospital uncompensated care payment am		350, 589 2, 064, 936		35.0 36.0
0.00	Total uncompensated care (sum of columns 1 and 2 on line 35. Additional payment for high percentage of ESRD beneficiary d			l	30.0
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.0
0.00	652, 682, 683, 684 and 685 (see instructions)	, al contar goo i or ino price			
			Before 1/1	On/After 1/1	
			1.00	1.01	
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0	0	41.0
1 01	instructions)		4		4.1
1. 01	Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions)	о-икus 652, 682, 683, 68	4 0	0	41.0
2.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.0
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43.0
0.00	instructions)				
4.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.0
	days)				
5.00	Average weekly cost for dialysis treatments (see instruction	2	0.00	0.00	
6.00	Total additional payment (line 45 times line 44 times line 4	1.01)	0		46.
7.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	amall rural bacanitala	16, 316, 943		47.
8.00	only. (see instructions)	smart rurar nospitars	14, 818, 881		48.
		·		Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instruction			16, 316, 943	49.0
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a)	1, 135, 536	
1.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.
2.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions)		0	52.
3.00	Nursing and Allied Health Managed Care payment			0	53. 54.
4.00 4.01	Special add-on payments for new technologies Islet isolation add-on payment			0	54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.
	Cost of physicians' services in a teaching hospital (see int			Ő	56.
6.00	Routine service other pass through costs (from Wkst. D, Pt.				
	ROULINE SERVICE ULIER PASS LINUUGII COSLS (TIUM WKSL. D, PL.		through 35).	0	
6.00 7.00 8.00	Ancillary service other pass through costs from Wkst. D, Pt.	III, column 9, lines 30	through 35).	0	57. 58.
7.00 8.00	Ancillary service other pass through costs (from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	III, column 9, lines 30	through 35).	-	57. 58.
7.00 8.00 9.00 0.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	III, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 17, 452, 479 29, 397	57. 58. 59. 60.
7.00 8.00 9.00 0.00 1.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu	III, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 17, 452, 479 29, 397 17, 423, 082	57. 58. 59. 60. 61.
7.00 8.00 9.00 0.00 1.00 2.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	III, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780	57. 58. 59. 60. 61. 62.
7.00 8.00 9.00 0.00 1.00 2.00 3.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	III, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924	57. 58. 59. 60. 61. 62. 63.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	III, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701	57. 58. 59. 60. 61. 62. 63. 64.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	III, column 9, lines 30 IV, col. 11 line 200) us line 60)	through 35).	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706	57. 58. 59. 60. 61. 62. 63. 64. 65.
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	III, column 9, lines 30 IV, col. 11 line 200) us line 60)	through 35).	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591	57. 58. 59. 60. 61. 62. 63. 64. 65. 66.
7.00 3.00 9.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	III, column 9, lines 30 IV, col. 11 line 200) us line 60) structions)		0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	III, column 9, lines 30 IV, col. 11 line 200) us line 60) structions)	see instructions)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68.
7.00 3.00 9.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 9.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	III, column 9, lines 30 IV, col. 11 line 200) us line 60) structions)	see instructions)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0	57. 58. 59. 60. 61. 62. 63. 64.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 4.00 5.00 6.00 7.00 3.00 9.00 0.00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	III, column 9, lines 30 IV, col. 11 line 200) us line 60) structions) applicable to MS-DRGs (.(For SCH see instructio	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69.
7.00 8.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<pre>III, column 9, lines 30 IV, col. 11 line 200) us line 60) structions) applicable to MS-DRGs (. (For SCH see instructio stration) adjustment (see</pre>	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
7.00 3.00 9.00 1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00 9.00 0.00 0.50 0.87	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	<pre>III, column 9, lines 30 IV, col. 11 line 200) us line 60) structions) applicable to MS-DRGs (. (For SCH see instructio stration) adjustment (see</pre>	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0 0 0	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70.
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.50 0.50 0.87 0.88 0.89	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	III, column 9, lines 30 IV, col. 11 line 200) us line 60) tructions) applicable to MS-DRGs ((For SCH see instruction) stration) adjustment (see	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0 0 0 0 0 0 0 0 0 0	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70.
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.50 0.50 0.87 0.88 0.89 0.90	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	III, column 9, lines 30 IV, col. 11 line 200) us line 60) tructions) applicable to MS-DRGs ((For SCH see instruction) stration) adjustment (see	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0 0 0 0 0 0 0	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70.
7. 00 3. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 5. 00 5. 00 9. 00 9. 00 9. 00 0. 50 0.	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	III, column 9, lines 30 IV, col. 11 line 200) us line 60) tructions) applicable to MS-DRGs ((For SCH see instruction) stration) adjustment (see	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70. 70.
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 88 0. 88 0. 89 0. 90 0. 00 0. 00 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	III, column 9, lines 30 IV, col. 11 line 200) us line 60) tructions) applicable to MS-DRGs ((For SCH see instruction) stration) adjustment (see	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70. 70. 70
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.50 0.50 0.87 0.88	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	III, column 9, lines 30 IV, col. 11 line 200) us line 60) tructions) applicable to MS-DRGs ((For SCH see instruction) stration) adjustment (see	see instructions) ns)	0 17, 452, 479 29, 397 17, 423, 082 1, 860, 780 22, 924 165, 701 107, 706 20, 591 15, 647, 084 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57 58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70 70 70 70 70

alth Financial Systems MARION GENERAL ALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN· 15-0011	Peri od:	u of Form CMS-2 Worksheet E	
			From 07/01/2018	Part A	
			To 06/30/2019	Date/Time Pre 11/25/2019 10	pare
	Title	XVIII	Hospi tal	PPS	. 30
	, in the		(yyyy)	Amount	
			0	1.00	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		0	0	70.
the corresponding federal year for the period prior to 10/1)					
0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter			0	0	70.
the corresponding federal year for the period ending on or a	after 10/1)			0	
).98 Low Volume Payment-3).99 HAC adiustment amount (see instructions)				0 175, 087	
).99 HAC adjustment amount (see instructions) 1.00 Amount due provider (line 67 minus lines 68 plus/minus lines	5 60 & 70)			15, 528, 194	
.01 Sequestration adjustment (see instructions)	S 07 & 70)			310, 564	
. 02 Demonstration payment adjustment amount after sequestration				0	
2. 00 Interim payments				15, 410, 909	
8.00 Tentative settlement (for contractor use only)				0	73.
1.00 Balance due provider/program (line 71 minus lines 71.01, 71.	02, 72, and			-193, 279	
73)					
6.00 Protested amounts (nonallowable cost report items) in accord	dance with			271, 483	75
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1		
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sur	n of 2.03			0	90
plus 2.04 (see instructions)				0	01
.00 Capital outlier from Wkst. L, Pt. I, line 2 .00 Operating outlier reconciliation adjustment amount (see inst	tructions)			0	
.00 Operating outlier reconciliation adjustment amount (see inst .00 Capital outlier reconciliation adjustment amount (see instru				0	
.00 The rate used to calculate the time value of money (see inst				0.00	
.00 Time value of money for operating expenses (see instructions				0.00	
0.00 Time value of money for capital related expenses (see instru					
, ou prime value of money for capital related expenses (see fisting	JCTIONS)			0	96
	uctions)		Prior to 10/1		96.
	JCTI ONS)		Prior to 10/1 1.00		96.
HSP Bonus Payment Amount	JCTI ONS)		1.00	0n/After 10/1 2.00	
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions)				0n/After 10/1 2.00	100
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	0n/After 10/1 2.00 0	100
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)			0.000000000	0n/After 10/1 2.00 0 0.000000000	100
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction			1.00	0n/After 10/1 2.00 0 0.000000000	100
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment			1.00 0 0.000000000 0	0n/After 10/1 2.00 0 0.000000000 0	100 101 102
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions)	ons)		0.000000000	0n/After 10/1 2.00 0.000000000 0.000000000 0.0000	100 101 102 103
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions)	ons)	ustment	1.00 0 0.000000000 0 0.0000	0n/After 10/1 2.00 0.000000000 0.000000000 0.0000	100 101 102 103
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p	ons) ns) strati on) Adji		1.00 0 0.000000000 0 0.0000	0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0.0000 0	100 101 102
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration project Century Cures Act? Enter "Y" for yes or "N" for no.	ons) ns) strati on) Adji		1.00 0 0.000000000 0 0.0000	0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ons) stration) Adji period under		1.00 0 0.000000000 0 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104 200
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii	ons) stration) Adji period under		1.00 0 0.000000000 0 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0	100 101 102 103 104 200
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions)	ons) stration) Adji period under		1.00 0 0.000000000 0 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0	100 101 102 103 104 200 201 201
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment for HSP Bonus Payment 2.00 HVBP adjustment for HSP Bonus payment (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration project (§410A Demonstration project (see instruction project Rural Community Hospital Demonstration Project (S410A Demonstration project Rural Community Rural Sector S	ons) hs) stration) Adji beriod under ne 49)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104 200 201 201
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment amount for HSP bonus payment (see instruction for Rural Community Hospital Demonstration Project (§410A Demonstration project (§410A Demonstration project (§410A Demonstration project (S410A Demonstration for HSP bonus payment for no. Cost Reimbursement 1.00 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A instructions)	ons) hs) stration) Adji beriod under ne 49)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104 200 201 201
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 2000) 0.0 Is this the first year of the current 5-year demonstration project (see instruction project (see instruction project (see instruction project cost see instruction project cost see instruction project cost see instructions) 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period)	ons) hs) stration) Adji beriod under ne 49)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0 tration	100 101 102 103 104 200 201 202 203
HSP Bonus Payment Amount D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 20.00 Is this the first year of the current 5-year demonstration project (set instruction project (set instructions) 0.00 Is the first year of the current 5-year demonstration project (set instructions) 0.00 Nedicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 1.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount	ons) hs) stration) Adji beriod under ne 49)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0 trati on	100 101 102 103 104 200 201 202 203 203
HSP Bonus Payment Amount D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1. 00 HVBP adjustment factor (see instructions) 2. 00 HVBP adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 20.00) 1. sthis the first year of the current 5-year demonstration project (see instructions) 0. 00 Is this the first year of the current 5-year demonstration project (see instructions) 0. 00 Is this the first year of the current 5-year demonstration project (see instructions) 0. 00 Is this sthe first year of the current 5-year demonstration project (see instructions) 0. 00 Gost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2. 00 Case-mix adjustment factor (see instructions) 3. 00 Case-mix adjustment factor (see instructions) 3. 00 Case-mix adjustment factor (see instructions) 3. 00 Case-mix adjustment factor (see instructions) 4. 00 Medicare target amount 5. 00	ons) stration) Adji period under ne 49) n first year	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0 trati on	100 101 102 103 104 200 201 202 203 203 204 204 205
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 6.00 Is the first year of the current 5-year demonstration project (§410A Demons 0.00 1.11 Is the first year of the current 5-year demonstration project (S410A Demons 0.00 2.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204)	ons) stration) Adji period under ne 49) n first year	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0 trati on	100 101 102 103 104
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 3.00 HRR Adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 2000) 5.00 Is this the first year of the current 5-year demonstration project (set instruction procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount for Langet Amount Limitation (N/A i period) 4.00 Medicare target amount (line 203 times line 204)	ons) hs) stration) Adju beriod under ne 49) n first year	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104 200 201 202 203 203 204 205 206
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction project (§410A Demons 0.01 Is this the first year of the current 5-year demonstration project (see instructions) 0.00 Is this the first year of the current 5-year demonstration project (see instructions) 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 204) 6.00 Medicare part A inpatient Reimbursement <	ons) hs) stration) Adji beriod under ne 49) n first year 5) structions)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0.000000000 0.0000 0.0000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	100 101 102 103 104 200 201 202 203 203 204 204 205
HSP Bonus Payment Amount D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 6.00 Is this the first year of the current 5-year demonstration project (\$410A Demons century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Computation of Demonstration Target Amount Limitation (N/A i period) 8.00 Medicare target amount 5.00 Case-mix adjustment factor (see instructions) 6.00 Medicare target amount 5.00 Case-mix adjustment factor (see instructions) 6.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare target amount 6.00 Medicare inpatient routine cost cap (line 202 times line 204) 6.00 Medicare Part A inpatient service costs (fro	ons) hs) stration) Adji beriod under ne 49) n first year 5) structions)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	100 101 102 103 104 200 201 202 203 204 205 206 206 207 208 209
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instructions) 3.00 HRR adjustment for HSP Bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 1.00 HVB first year of the current 5-year demonstration project (S410A Demons 0.00 1.00 Hodicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) 00 00 Redicare Part A inpa	ons) stration) Adji period under ne 49) n first year 5) structions) A, line 59)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instructions) 3.00 HRR adjustment for HSP Bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration protect (§410A Demonstration (N/A i period) 1.00 Medicare target amount 2.00 Medicare target amount 3.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 204) 6.00 Medicare part A inpatient service costs (from Wkst. E, Pt. A) 9.00 Adjustment to Medicare IPPS payments (see instructions) </td <td>ons) stration) Adji period under ne 49) n first year 5) structions) A, line 59)</td> <td>the 21st</td> <td>1.00 0.000000000 0.000000000 0.0000 0.0000</td> <td>0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210</td>	ons) stration) Adji period under ne 49) n first year 5) structions) A, line 59)	the 21st	1.00 0.000000000 0.000000000 0.0000 0.0000	0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment 3.00 HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (S410A Demonstration Project (S410A Demonstration Project Rural Community Hospital Demonstration Project (S410A Demonstration (N/A i period) 0.00 Medicare target amount 1.000 Medicare target amount 1.001 Medicare target amount 1.002 Medicare target amount 1.003 Case-mix adjusted target amount (Line 203 times Line 204) 0.004 Medicare Part A inpatient service costs (from Wkst.	ons) hs) stration) Adji beriod under ne 49) n first year 5) structions) A, line 59) s)	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0n/After 10/1 2.00 0.000000000 0.0000 0.0000 0 trati on	100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVR adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction fural Community Hospital Demonstration Project (§410A Demons of the current 5-year demonstration project (set instruction fural Community Hospital Demonstration Project (set instructions) 0.00 Is this the first year of the current 5-year demonstration project (cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare Part A Inpatient Re	ons) hs) stration) Adji beriod under ne 49) n first year 5) structions) A, line 59) s)	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0n/After 10/1 2.00 0.000000000 0.0000 0.0000 0 trati on	100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211 212
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 6.00 Is the first year of the current 5-year demonstration project (§410A Demonstration project (S410A Demonstration project (S410A Demonstration project (see instructions) 0.00 Is this the first year of the current 5-year demonstration project (see instructions) 0.00 Is this the first year of the current 5-year demonstration project (see instructions) 0.00 Is this the first year of the current 5-year demonstration project (see instructions) 0.00 Redicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 0.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 20	ons) stration) Adj stration) Adj period under ne 49) n first year 5) structions) A, line 59) S) = 211)	of the curr	1.00 0.000000000 0.000000000 0.0000 0	0n/After 10/1 2.00 0.000000000 0.0000 0.0000 0 tration	100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211

LOW VC	DLUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0011	Period: From 07/01/2018 To 06/30/2019		pared:
				Title	XVIII	Hospi tal	PPS	. JU di
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01		Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
. 00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.0
. 01	payments DRG amounts other than outlier payments for discharges	1.01	3, 508, 863	0	3, 508, 86	53	3, 508, 863	1.0
. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	10, 128, 960	0		10, 128, 960	10, 128, 960	1.0
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0		0	0	1.0
1.04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	Ο	0		0	0	1.0
. 00	Outlier payments for discharges (see instructions)	2.00	96, 288	0		0 96, 288	96, 288	2.0
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	
3.00	Operating outlier reconciliation	2.01	0	0		0 0	0	3.0
1.00	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0		0 0	0	4.0
. 00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0. 000000		5.0
. 00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0 0	0	
. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0		0 0	0	6. C
	i nstructi ons)							
	Indirect Medical Education Adj	ustment for th	e Add-on for Se	ection 422 of	the MMA			1
. 00	IME payment adjustment factor	27.00	0. 000000	0.00000	0.00000	0. 000000		7.0
00	(see instructions) IME adjustment (see instructions)	28.00	0	0		0 0	0	8.0
. 01	IME payment adjustment add on for managed care (see	28.01	0	0		0 0	0	8.0
. 00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	9.0
. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0		0 0	0	9.0
	Disproportionate Share Adjustm		0.4540		0.454	0 0 1510		1
0.00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1519	0. 1519	0. 151	9 0. 1519		10.0
	Disproportionate share adjustment (see instructions)	34.00	517, 896	0			517, 896	
1. 01	Uncompensated care payments Additional payment for high pe	36.00	2,064,936	di scharges	350, 58	39 1, 714, 347	2, 064, 936	11.0
2.00	Total ESRD additional payment (see instructions)	46.00	0	0 o		0 0	0	12.0
3.00 4.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	16, 316, 943 0	0 0	3, 992, 70	01 12, 324, 242 0 0	16, 316, 943 0	
5. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	16, 316, 943	0	3, 992, 70	12, 324, 242	16, 316, 943	15.0
5.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 135, 536	0	295, 90		1, 135, 536	
	Special add-on payments for new technologies Net organ aquisition cost	54.00	0	0		0 0	0	
7.01 7.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.0 17.0

	Financial Systems		MARION GENERA				u of Form CMS-	2552-1
LOW VO	ULUME CALCULATION EXHIBIT 4				CN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 10	pared:
					× XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prio		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	C		0 0	C	18.00
19.00	SUBTOTAL			0	4, 288, 60	05 13, 163, 874	17, 452, 479	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1, 109, 867	0	285, 73	824, 133	1, 109, 867	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0		0 0	C	20.01
21.00	Capital DRG outlier payments	2.00	25, 669	0	10, 1	70 15, 499	25, 669	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	C		0 0	C	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	C		0 0	C	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	C		0 0	C	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 135, 536	C	295, 90	839, 632	1, 135, 536	26.00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.0000	0. 000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	C	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	С	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

SPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 07/01/2018 To 06/30/2019	Date/Time Prep 11/25/2019 10:	pared
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	XVIII Period to 10/01	Hospital Period on after 10/01	PPS Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges exercises reises to October 1	1. 00 1. 01	3, 508, 863	3, 508, 86	53	3, 508, 863	1. 1.
02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10, 128, 960		10, 128, 960	10, 128, 960	1.
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1
00	Outlier payments for discharges (see instructions)	2.00	96, 288		0 96, 288	96, 288	2
01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2
00 00	Operating outlier reconciliation Managed care simulated payments Indirect Medical Education Adjustment	2. 01 3. 00	0		0 0 0 0	0	3 4
00	Amount from Worksheet E, Part A, Line 21 (see instructions)	21.00	0. 000000	0. 00000	0.00000		5
00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6
D1	IME payment adjustment for managed care (see instructions)		0		0 0	0	6
00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	0. 000000	0. 00000	0. 000000		7
00	instructions)	27.00	0.000000	0.00000	0.00000		<i>'</i>
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0 0 0	0 0	8 8
00 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29. 00 29. 01	0		0 0 0 0	0 0	9 9
00	Allowable disproportionate share percentage	33.00	0. 1519	0. 151	0. 1519		10
	(see instructions)					547.00/	
	Disproportionate share adjustment (see instructions)	34.00	517, 896	133, 24		517, 896	
. 01	Uncompensated care payments	36.00	2,064,936	350, 58	39 1, 714, 347	2,064,936	11
. 00	Additional payment for high percentage of ESI Total ESRD additional payment (see	46.00	0 oli scharges		0 0	0	12
	instructions)						
00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	16, 316, 943 0	3, 992, 70	0 12, 324, 242 0 0	16, 316, 943 0	13 14
00	Total payment for inpatient operating costs (see instructions)	49.00	16, 316, 943	3, 992, 70	12, 324, 242	16, 316, 943	15
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 135, 536	295, 90	839, 632	1, 135, 536	16
. 00	Special add-on payments for new technologies Net organ acquisition cost		0		0 0		17
. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0	0	
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	
. 00	SUBTOTAL	1		4, 288, 60	05 13, 163, 874	17, 452, 479	l 10

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 07/01/2018 To 06/30/2019	Date/Time Pre 11/25/2019 10	epared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1, 109, 867	285, 73		1, 109, 867	20.00
	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	25, 669	10, 17	0 15, 499	25, 669	21.00
	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0 0. 0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 000	0 0. 0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 135, 536	295, 90	4 839, 632	1, 135, 536	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	
30.00	HVBP payment adjustment (see instructions)	70. 93	66, 716	6,40	8 60, 308	66, 716	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-10, 519	-1,40	4 -9, 115	-10, 519	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99		42, 93		175, 087	32.00
100. 00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

	Financial Systems MARION GENERAL HC			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2018	Worksheet E Part B	
			To 06/30/2019	Date/Time Pre	
		Title XVIII	Hospi tal	11/25/2019 10 PPS	: 38 811
	PART B - MEDI CAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			1, 242	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		20, 129, 240	
3.00	OPPS payments			18, 961, 698	3.00
4.00 4.01	Outlier payment (see instructions)			134, 761 0	4.00 4.01
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	tions)		0.000	5.00
6.00	Line 2 times line 5			0.000	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	/, col. 13, line 200		0	9.00 10.00
11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			1, 242	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 212	11.00
	Reasonabl e charges				
12.00	Ancillary service charges	(0)			12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir Total reasonable charges (sum of lines 12 and 13)	ie 69)		0 7, 222	13.00 14.00
14.00	Customary charges			1,222	14.00
15.00	Aggregate amount actually collected from patients liable for pa			0	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))		0,000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000 7,222	
19.00	Excess of customary charges over reasonable cost (complete only	yifline 18 exceeds l	ine 11) (see	5, 980	
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds l	ine 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			1 242	21.00
	Interns and residents (see instructions)			1, 242	
	Cost of physicians' services in a teaching hospital (see instru		0	23.00	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	19, 096, 459	24.00		
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u>,</u>		0	25.00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line		ructions)	0 3, 710, 870	25.00 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			15, 386, 831	
	instructions)				
28.00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 15, 386, 831	29.00 30.00
	Primary payer payments			2, 681	
	Subtotal (line 30 minus line 31)			15, 384, 150	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
	Composite rate ESRD (from Wkst. 1-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			794, 394 516, 356	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		511, 880	
	Subtotal (see instructions)	· · · · · · · · · · · · · · · · · · ·		15, 900, 506	
	MSP-LCC reconciliation amount from PS&R			-181	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	N		0	39.00
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration)		0	39.50 39.97
39.97 39.98	Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	0	39.97
39.99			/	0	39.99
40.00	Subtotal (see instructions)			15, 900, 687	40.00
40.01	Sequestration adjustment (see instructions)			318, 014	40.01
	Demonstration payment adjustment amount after sequestration Interim payments			0 15, 659, 562	40.02
	Tentative settlement (for contractors use only)			15, 059, 502	41.00
43.00	Balance due provider/program (see instructions)			-76, 889	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2				
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money			-	92.00
93.00	Time Value of Money (see instructions)			0	93.00 94.00
04 00	Total (sum of lines 91 and 93)				

ANALY	n Financial Systems MARION GENERA SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	AL HOSPITAL Provider C	CN: 15-0011	Period: From 07/01/2018 To 06/30/2019		pared:
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		15, 228, 9	50 0	15, 076, 097 0	1.00 2.00 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					
3. 01	ADJUSTMENTS TO PROVIDER	07/24/2019	119, 4	59 07/24/2019	583, 465	3.0'
3. 02		01/15/2019	62, 50		0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3. 05	Provider to Program			0	0	3.0
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.5
3.51				0	0	3.5
3. 52				0	0	3.5
3.53				0	0	3.5
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		181, 9	0	0 583, 465	3.5 3.9
). 77	3. 50-3. 98)		101, 7	57	565, 405	3.7
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E–3, line and column as appropriate)		15, 410, 90	09	15, 659, 562	4.0
	TO BE COMPLETED BY CONTRACTOR					
6. 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)					5.C
	Program to Provider					
6. 01 6. 02	TENTATI VE TO PROVIDER			0	0	5. C
5.02 5.03				0	0	
. 00	Provider to Program					0.0
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5.51				0	0	
. 52 . 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.5 5.9
. 77	5. 50-5. 98)			0	0	J. 7
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
0.01	SETTLEMENT TO PROVIDER		100.0	0	0	6.0
0. 02 . 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		193, 2 ⁻ 15, 217, 6		76, 889 15, 582, 673	6.0 7.0
. 00			15,217,0	Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0011 CCN: 15-T011	Period: From 07/01/201 To 06/30/201		epared:
		Title	e XVIII	Subprovider - IRF	- PPS	
		I npati er	nt Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
. 00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	0 1.0
. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5,755,2	0		0 2.00
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
01	ADJUSTMENTS TO PROVIDER			0		0 3.0 [.]
02				0		0 3.0
03 04				0		0 3.0 0 3.0
04				0		0 3.0
	Provider to Program		1	-		-
. 50	ADJUSTMENTS TO PROGRAM			0		0 3.5
51				0		0 3.5
52 53				0		0 3.5 0 3.5
54				0		0 3.5
. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		0 3.9
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 735, 2	.42		0 4.0
	TO BE COMPLETED BY CONTRACTOR					
. 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)					5.0
	Program to Provider		1		-	
. 01 . 02	TENTATI VE TO PROVIDER			0		0 5.0 0 5.0
. 02				0		0 5.0
	Provider to Program		1		`	
. 50	TENTATI VE TO PROGRAM			0		0 5.5
. 51				0		0 5.5
. 52 . 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0 5.5 0 5.9
. 99	5. 50-5. 98)			0		0 0.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER		36, 0	076		0 6.0
. 02 . 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		3, 771, 3	U 18		0 6.0 0 7.0
. 00			3,771,3	Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	8.0

Heal th	Financial Systems MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS	-2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019		epared:	
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		e 14		1.00	
2.00						
3.00	8.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (see instructions)				8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00	

	Financial Systems MARION GENERAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2018	Worksheet E-3	
		Component CCN: 15-T011	To 06/30/2019	Date/Time Pre	
		Title XVIII	Subprovi der -	11/25/2019 10 PPS	. 30 di
			I RF		
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
I. 00	Net Federal PPS Payment (see instructions)			3, 735, 919	1.0
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0217	2.0
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			123, 285	3.0
1.00	Outlier Payments			44, 500	
5.00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period e	nding on or prior	0.00	5.0
5. 01	Cap increases for the unweighted intern and resident FTE cou			0.00	5.0
	program or hospital closure, that would not be counted witho	out a temporary cap adjus	tment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
5.00 7.00	New Teaching program adjustment. (see instructions)	the new program growth	ported of a "now	0.00 0.00	
. 00	Current year's unweighted FTE count of I&R excluding FTEs in teaching program" (see instructions)	the new program growth		0.00	/.0
3. 00	Current year's unweighted I&R FTE count for residents within	the new program growth	period of a "new	0.00	8.0
9.00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education adju	stmont (soo instructions		0.00	9.0
10.00	Average Daily Census (see instructions))	7. 728767	
11.00	Teaching Adjustment Factor (see instructions)			0. 000000	
2.00	Teaching Adjustment (see instructions)			0.000000	12.0
3.00	Total PPS Payment (see instructions)			3, 903, 704	
4.00	Nursing and Allied Health Managed Care payments (see instruc	tion)		0	14.0
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.0
6.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
7.00	Subtotal (see instructions)			3, 903, 704	
8.00	Primary payer payments			0	
9.00	Subtotal (line 17 less line 18).			3, 903, 704	
21.00	Deductibles Subtotal (line 19 minus line 20)			55, 420 3, 848, 284	
22.00	Coi nsurance			0,040,204	22.0
23.00	Subtotal (line 21 minus line 22)			3, 848, 284	
	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		0	24.0
25.00	Adjusted reimbursable bad debts (see instructions)	, , , , , , , , , , , , , , , , , , , ,		0	25.0
6.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	26.0
27.00	Subtotal (sum of lines 23 and 25)			3, 848, 284	
8.00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	28.0
9.00	Other pass through costs (see instructions)			0	29.0
0.00 1.00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.0 31.0
1.50	Pioneer ACO demonstration payment adjustment (see instructio	(sau		0	31.
1.99	Demonstration payment adjustment amount before sequestration	-		0	
2.00	Total amount payable to the provider (see instructions)			3, 848, 284	
2.01	Sequestration adjustment (see instructions)			76, 966	
2. 02	Demonstration payment adjustment amount after sequestration			0	32.0
3.00	Interim payments			3, 735, 242	33. (
34.00	Tentative settlement (for contractor use only)			0	34.0
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.	· · · · · ·		36, 076	
36.00	Protested amounts (nonallowable cost report items) in accord §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	36. C
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			44, 500	
51.00 52.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	51.0 52.0
J∠. UU	Time Value of Money (see instructions)			0.00	1.02.0

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Peri od:	Worksheet E-3	3
			From 07/01/2018 To 06/30/2019		epared:):38 am
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	TICES FOR TITLES V OR	XIX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		1, 167, 434		1.00
2.00	Medical and other services		1, 107, 434	0	
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 167, 434	0	1
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 167, 434	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		1, 155, 966	0	8.00
9.00	Ancillary service charges		2, 176, 052	0	
10.00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.00
11.00 12.00	Total reasonable charges (sum of lines 8 through 11)		3, 332, 018	0	1
12.00	CUSTOMARY CHARGES		5, 552, 010	0	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
101.00	basi s	sei troce en a enarge		Ū	
14.00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.00000	15.00	
16.00	Total customary charges (see instructions)		3, 332, 018	0	
17.00	Excess of customary charges over reasonable cost (complete only	2, 164, 584	0	17.00	
	line 4) (see instructions)				10.00
18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds li	ne 0	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
20.00	Cost of covered services (enter the lesser of line 4 or line 16	-	1, 167, 434	0	1
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of			0	21.00
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	1
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		1, 167, 434	0	29.00
~~ ~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 167, 434	0	
32.00	Deductibles		0	0	
33.00	Coinsurance Allowable bad debts (see instructions)		0	0	00.00
35.00			0	0	34.00
36.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	1
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
38.00	Subtotal (line 36 ± line 37)			0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		1, 167, 434 0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1, 167, 434	0	
41.00	Interim payments		1, 566, 048	0	
42.00	Balance due provider/program (line 40 minus line 41)		-398, 614	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				1

		Provider CCN: 15-0011	From 07/01/2018	Worksheet E-3 Part VII	,
		Component CCN: 15-T011	To 06/30/2019	Date/Time Pre 11/25/2019 10	
		Title XIX	Subprovi der – I RF	Cost	
			I npati ent	Outpati ent	—
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		238, 739		7 -
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		238, 739	0	
00	Inpatient primary payer payments		0	0	5
00 00	Outpatient primary payer payments		238, 739	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		230, 739	0	- '
	Reasonable Charges				1
00	Routi ne servi ce charges		0		1 8
00	Ancillary service charges		35, 403	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)	35, 403	0	1:	
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	1:
	basi s				
. 00	Amounts that would have been realized from patients liable for	on 0	0	1	
00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	1
. 00 . 00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000	
. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 16 exceeds			0	
. 00	Line 4) (see instructions)			0	
. 00	Excess of reasonable cost over customary charges (complete on	nlvifline 4 exceeds li	ne 203, 336	0	18
	16) (see instructions)	5			
. 00	Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		35, 403	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS prov			4
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	1 -
. 00 . 00	Program capital payments Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		35, 403	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
. 00	Excess of reasonable cost (from line 18)		203, 336	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	5)	35, 403	0	
	Deducti bl es		0	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review	22)	0 35, 403	0	3
. 00 . 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
. 00	Subtotal (line 36 ± 1 ine 37)	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			
	Direct graduate medical education payments (from Wkst. E-4)		35, 403	0	3
. 00	Total amount payable to the provider (sum of lines 38 and 39)		35, 403	0	
. 00	Interim payments		16, 073	0	
. 00	Balance due provider/program (line 40 minus line 41)		19, 330	0	
	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,			0	43

ly)	ype accounting records, complete the General Fund column		FI Te	rom 07/01/2018 o 06/30/2019	Date/Time Pre 11/25/2019 10	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS	0.445.045				
	Cash on hand in banks	8, 145, 245	0	0	0 0	
	Temporary investments Notes receivable	0	0	0	0	
	Accounts receivable	61, 281, 442	0	0	0	
	Other receivable	3, 649, 512	0	0	0	
	Allowances for uncollectible notes and accounts receivable		0	0	0	
00	Inventory	2, 052, 978	0	0	0	7.
	Prepaid expenses	3, 064, 771	0	0	0	
	Other current assets	926, 265	0	0	0	
	Due from other funds	0	0	0	0	
	Total current assets (sum of lines 1-10)	41, 388, 637	0	0	0	11.
-	FI XED ASSETS Land	5, 191, 829	0	0	0	12.
	Land improvements	3, 353, 531	0	0	0	
	Accumulated depreciation	-2, 783, 199	0	0	0	
	Buildings	139, 652, 632	0	0	0	
	Accumulated depreciation	-80, 278, 883	0	0	0	
	Leasehold improvements	3, 551, 213	0	0	0	17
00	Accumulated depreciation	-2, 554, 854	0	0	0	18
	Fixed equipment	3, 509, 530	0	0	0	
	Accumulated depreciation	-974, 767	0	0	0	
	Automobiles and trucks	1, 030, 564	0	0	0	
	Accumulated depreciation	-902, 041	0	0	0	
	Major movable equipment	70, 915, 959	0	0	0	
	Accumulated depreciation Minor equipment depreciable	-57, 698, 318	0	0	0	
	Accumulated depreciation		0	0	0	
	HIT designated Assets		0	0	0	
	Accumulated depreciation	0	0	0	0	
	Mi nor equi pment-nondepreci abl e	791, 164	0	0	0	
	Total fixed assets (sum of lines 12-29)	82, 804, 360	0	0	0	30
-	OTHER ASSETS	-				
	Investments	255, 286, 446	0	0	0	
	Deposits on Leases	0	0	0	0	
	Due from owners/officers	0 745 (00	0	0	0	
	Other assets Total other assets (sum of lines 31-34)	9, 715, 680	0	0	0	
	Total assets (sum of lines 11, 30, and 35)	265, 002, 126 389, 195, 123	0	0	0 0	
	CURRENT LIABILITIES	309, 195, 125	0	U	0	1 30
-	Accounts payable	5, 196, 908	0	0	0	37
	Salaries, wages, and fees payable	6, 172, 851	0	0	0	
	Payroll taxes payable	0	0	0	0	
00	Notes and Loans payable (short term)	0	0	0	0	40
. 00	Deferred income	0	0	0	0	41
	Accelerated payments	0				42
	Due to other funds	0	0	0	0	
	Other current liabilities	3, 192, 733	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	14, 562, 492	0	0	0	45
	LONG TERM LI ABI LI TI ES	0	0	ol	0	
	Mortgage payable Notes payable		0	0	0	
	Unsecured Loans		0	0	0	
	Other long term liabilities	81, 183, 555	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	81, 183, 555	0	0	0	
00	Total liabilities (sum of lines 45 and 50)	95, 746, 047	0	0	0	51
ŀ	CAPI TAL ACCOUNTS					
	General fund balance	293, 449, 076				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	~	56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
		293, 449, 076	0	о	0	59
00	Total fund balances (sum of lines 52 thru 58)					

Heal th	n Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATE	MENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet G-1 Date/Time Pre 11/25/2019 10	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balance at end of period per balance		282, 727, 185 10, 721, 891 293, 449, 076 293, 449, 076 293, 449, 076 0 293, 449, 076	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATI ENT REVENUES AND OPERATI NG EXPENSES	Provider CC	CN: 15-0011	Period: From 07/01/2018 To 06/30/2019		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services		10 ((1 7		10 (11 71)	
1.00	Hospi tal		18, 661, 7		18, 661, 744	1.00
2.00	SUBPROVIDER - IPF		3, 619, 0		3, 619, 018	2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER			0	0	3.00 4.00
4.00 5.00	Swing bed - SNF			0		5.00
6.00	Swing bed - NF			0		6.00
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		22, 280, 7	52	22, 280, 762	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T		6, 914, 6	47	6, 914, 647	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL INTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	с. I.I.				15.00
16.00	Total intensive care type inpatient hospital services (sum o	r lines	6, 914, 6	47	6, 914, 647	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 10	4)	29, 195, 40	0	29, 195, 409	17.00
17.00	Ancillary services	0)	81, 907, 64			18.00
19.00	Outpatient services		01, 707, 0	0 351, 357, 654	351, 357, 654	19.00
20.00	RURAL HEALTH CLINIC			0 0		20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES			0 4, 437, 465	4, 437, 465	23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	PHYSICIAN PRACTICE			0 53, 940, 292		27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	111, 103, 0	56 409, 735, 411	520, 838, 467	28.00
	G-3, line 1)					
29.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)		[185, 946, 618		29.00
30.00	ELIMINATIONS		-1,088,5			30.00
31.00	BAD DEBT ADJUSTMENT		-655, 1			31.00
32.00			000,1	0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			-1, 743, 636		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00	Tatal daduations (sum of Lines 27 (1)			0		41.00
42.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 4	(1) (transform		194 202 092		42.00
43.00	to Wkst. G-3, line 4)	42) (transfer		184, 202, 982		43.00
		· · · ·	I	T	I	I

Health Financial Systems MARION GENERAL HOSPITAL		IOSPI TAL	In Lieu of Form CMS-2552-10			
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0011	Period:	Worksheet G-3	
				From 07/01/2018 To 06/30/2019	Date/Time Pre	nared
				10 00/ 30/ 2017	11/25/2019 10	: <u>38 am</u>
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Par				520, 838, 467	1.00
2.00	Less contractual allowances and discounts of	n patients' account	ts		340, 836, 766	2.00
3.00	Net patient revenues (line 1 minus line 2)				180, 001, 701	3.00
4.00	Less total operating expenses (from Wkst. G		43)		184, 202, 982	4.00
5.00					-4, 201, 281	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				13, 079, 283	7.00
8.00	Revenues from telephone and other miscelland	eous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00				0	13.00	
14.00	Revenue from meals sold to employees and gue	ests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical su		nan patrents		0	16.00 17.00
17.00 18.00	Revenue from sale of drugs to other than par Revenue from sale of medical records and ab				0	17.00
18.00					0	18.00
20.00		,			0	20.00
20.00	Revenue from gifts, flowers, coffee shops, a Rental of vending machines	and canteen			0	20.00
21.00	Rental of hospital space					21.00
22.00					0	22.00
23.00	Governmental appropriations OTHER REVENUE				0 1, 879, 944	23.00
24.00 25.00					1, 879, 944	24.00 25.00
25.00 26.00	Total other income (sum of lines 6-24) Total (line 5 plus line 25)				14, 959, 227	25.00 26.00
26.00	BAD DEBT EXPENSE				36, 055	26.00
27.00	Total other expenses (sum of line 27 and su	beerinte)			36,055	27.00
	Net income (or loss) for the period (line 2)				10, 721, 891	
27.00	Iner medile (di 1055) fui the period (The zi	o minus inne 20)		I	10, 721, 091	27.00

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0011	Period: From 07/01/2018	u of Form CMS-255 Worksheet L Parts I-III			
		To 06/30/2019	Date/Time Pre 11/25/2019 10	pare		
	Title XVIII	Hospi tal	PPS			
			1.00			
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				-		
00 Capital DRG other than outlier			1, 109, 867	1 1.		
01 Model 4 BPCI Capital DRG other than outlier			0	1.		
00 Capital DRG outlier payments			25, 669	2.		
01 Model 4 BPCI Capital DRG outlier payments			0	1 -		
00 Total inpatient days divided by number of days in	the cost reporting period (see inst	ructions)	47.68 0.00			
	Number of interns & residents (see instructions)					
1 5 1	Indirect medical education percentage (see instructions)					
1.01) (see instructions)	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)					
00 Percentage of SSI recipient patient days to Medic. 30) (see instructions)	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)					
00 Percentage of Medicaid patient days to total days	0.00	8				
	Sum of lines 7 and 8					
.00 Disproportionate share adjustment (see instructio			0	1		
.00 Total prospective capital payments (see instruction	ons)		1, 135, 536	12		
		-	1.00			
PART II - PAYMENT UNDER REASONABLE COST			0	1 1		
00 Program inpatient routine capital cost (see instruction) 00 Program inpatient ancillary capital cost (see ins			0			
00 Total inpatient program capital cost (see fils			0			
00 Capital cost payment factor (see instructions)	The z)		0	-		
00 Total inpatient program capital cost (line 3 x li	ne 4)		0			
		-	1.00			
PART III - COMPUTATION OF EXCEPTION PAYMENTS						
00 Program inpatient capital costs (see instructions			0			
00 Program inpatient capital costs for extraordinary	. , , ,		0			
Net program inpatient capital costs (line 1 minus			0			
Applicable exception percentage (see instructions Capital cost for comparison to payments (line 3 x			0.00			
00 Percentage adjustment for extraordinary circumsta			0.00			
00 Adjustment to capital minimum payment level for e		line 6)	0.00			
Capital minimum payment level (line 5 plus line 7	5		0			
00 Current year capital payments (from Part I, line			0	9		
00 Current year comparison of capital minimum paymen		less line 9)	0	10		
.00 Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)	level over capital payment (from pri	or year	0	11.		
.00 Net comparison of capital minimum payment level to			0	12		
.00 Current year exception payment (if line 12 is pos			0			
.00 Carryover of accumulated capital minimum payment (if line 12 is negative, enter the amount on this		ollowing period	0	14		
			0	15		
.00 Current year allowable operating and capital paym						
.00 Current year allowable operating and capital paym .00 Current year operating and capital costs (see ins .00 Current year exception offset amount (see instruc	tructions)		0	16 17		