Health Financi	al Systems	MARION GENERAL HO			u of Form CMS-2552-10
This report is	required by law (42 USC 1395g; 42	CFR 413.20(b)). Failu	ire to report can resu	ılt in all interim	FORM APPROVED
payments made	since the beginning of the cost rep	orting period being o	leemed overpayments (4	2 USC 1395g).	омв но. 0938-0050
	OSPITAL HEALTH CARE COMPLEX COST RE		Provider CCN: 150011	Period:	Worksheet S
AND SETTLEMENT				From 07/01/2013	
				то 06/30/2014	Date/Time Prepared: 11/20/2014 2:51 pm
			1		111/20/2014 2:31 pm
PART I - COST				Date: 11/20/2	014 Time: 2:51 pm
Provider	1. [X] Electronically filed cost r			Date: 11/20/2	014 11me: 2:31 pm
use only	2. [] Manually submitted cost rep				
	3.[0] If this is an amended report. F] Medicare Utilization. Enter	rt enter the number o r "F" for full or "L"	f times the provider for low.	resubmitted this co	ost report
Contractor use only	(1) As Submitted 7. Con	e Received: stractor No.]Initial Report for]Final Report for t	this Provider CCN 12.	NPR Date: Contractor's Vendo [0]If line 5, co number of tim	or Code: 4 Dumn 1 is 4: Enter des reopened = 0-9.
PART II - CERT	IFICATION				
MISREPRESENTAT ADMINISTRATIVE PROVIDED OR PE	TION OR FALSIFICATION OF ANY INFORMA E ACTION, FINE AND/OR IMPRISONMENT U ROCURED THROUGH THE PAYMENT DIRECTLY	NDER FEDERAL LAW. FU	JRTHERMORE, IF SERVICE	S IDENTIFIED IN TH	IIS REPORT WERE
ADMINISTRATIVE	ACTION, FINES AND/OR IMPRISONMENT	MAY RESULT.			
	CERTIFICATION BY OFFICER OR ADMI	NISTRATOR OF PROVIDER	R(S)		
~ 1150	The Control that I have need the abo	wa contification sta	tomant and that I have	o ovemined the acco	amaanviba

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARION GENERAL HOSPITAL (150011) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)

Encryption Information
ECR: Date: 11/20/2014 Time: 2:51 pm
N4vkJeZxK7rwFMjpHB5mD2xg2krNJO
7FqnB0J3SmhGPB4h.Hk8dwRT3idu97
D2ns1nNN7D0ejCec
PI: Date: 11/20/2014 Time: 2:51 pm

PI: Date: 11/20/2014 Time: 2:51 pm T4sJwup8KBzwfUs6N.3UKdv1:zmb4O FVwns0B2He0245f0KjIXOdw1M]p5iA JZS6OObBKLOTuii4 Officerypy Administrator of Provider(s)

Title 11/21/14

Date /

Title XVIII Title V Part A Part B HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY -111,197 484,050 -1,923,028 1.00 -357,843 1.00 Hospital 0 2.00 Subprovider - IPF 0 2.00 Subprovider - IRF 0 -26,483 0 -26,562 3.00 3.00 0 o 4.00 4.00 SUBPROVIDER I 0 5.00 Swing bed - SNF 0 5.00 Swing bed - NF 0 6.00 6.00 0 -111,197 484,050 -1,949,590 200.00 -384,326 200.00 Total

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

Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150011 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 11/20/2014 2:46 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 441 WABASH AVENUE 1.00 PO Box: 1.00 State: IN 2.00 City: MARION Zip Code: 46952 County: GRANT 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fied T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MARION GENERAL HOSPITAL 150011 99915 07/01/1966 Ν Р 0 3.00 Hospi tal 1 Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF MARION GENERAL HOSPITAL 15T011 99915 5 07/01/2005 N Р 0 5.00 REHAB 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2013 06/30/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 Υ share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" used in the prior cost reporting period? In column 2 for ves or "N" for no In-State In-State Out-of Out-of Medicai d Other Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2. 00 3. 00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 1, 957 497 2, 256 24 00 in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state 98 0 0 0 25.00 Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.

		Urban/Rural S	Date of Geogr	
		1. 00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the	2		26.00
	cost reporting period. Enter "1" for urban or "2" for rural.			
27. 00	Enter your standard geographic classification (not wage) status at the end of the cost	2		27.00
	reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,			
	enter the effective date of the geographic reclassification in column 2.			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in	1		35.00
	effect in the cost reporting period.			

FTE unweighted count.

program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150011 Peri od: Worksheet S-2 From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 11/20/2014 2:46 pm Program Code Unweighted IME Program Name Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 0.00 61.20 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Non-Provider Settings 63.00 Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in FTES (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods

0. 00

0. 00

0.000000 66.00

66.00

beginning on or after July 1, 2010

Enter in column 1 the number of unweighted non-primary care resident

FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

ealth Financial Systems MARION GENERAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Period: From 07/01/2		u of Form Worksheet Part I	
			To 06/30/2		Date/Time	
			V		11/20/201 XI X	4 2: 46 pm
		 	1. 00		2. 00	107
07.00 Column 1: If this facility qualifies as a CAH, is it eligib for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on Wo 25 and the program would be cost reimbursed. If yes complete Column 2: If this facility is a CAH, do I&Rs in an approved train in the CAH's excluded IPF and/or IRF unit? Enter "Y" column 2. (see instructions) 08.00 Is this a rural hospital qualifying for an exception to the	o in column 1. orksheet B, Pa e Worksheet D- d medical educ for yes or "	(see rt I, column 2, Part II. ation program N" for no in	N N			107. (
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupational	Speech	1	Respi rat	
20 coll 6 this hamital mustifier as a CAU as a seat manifely	1.00	2.00	3.00		4. 00	100
09.00 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. (
				1. 00	2.00 3	. 00
Miscellaneous Cost Reporting Information 15.00 s this an all-inclusive rate provider? Enter "Y" for yes or enter the method used (A, B, or E only) in column 2. If colu either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital providers 15-1, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y"	umn 2 is "E", for long term s) based on th	enter in colum care (include e definition i	n 3 s	N Y		0 115. (
17.00 ls this facility legally-required to carry malpractice insurno.	ance? Enter "	Y" for yes or		Υ		117. (
18.00 Is the mal practice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	Premiums	Losses	1	Insuran	118. (
		1. 00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:		660, 49	6	0		0 118. (
			1. 00		2.00	
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 DO 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 	dule listing c d Harmless pro n column 1 "Y"	ost centers vision in ACA for yes or	N Y		Y	118. (119. (120. (
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2 "Y" for yes or "N" for no.	nts? (see inst	ructi ons)				
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	entable device	s charged to	N			121.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo	or yes and "N"	for no. If	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 ff this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2		fication date				126.
27.00 f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certif 2.					127.
28.00 f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 f this is a Medicare certified lung transplant center, ente	2.					128. 129.
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center,	enter the cer					130.
date in column 1 and termination date, if applicable, in col	, enter the c	erti fi cati on				131.
·		ication date				132.
date in column 1 and termination date, if applicable, in col 2.00 If this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certif 2.					
date in column 1 and termination date, if applicable, in col 32.00 If this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2 33.00 If this is a Medicare certified other transplant center, ent in column 1 and termination date, if applicable, in column 2	cer the certif 2. cer the certif 2.	ication date				
32.00 If this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2 33.00 If this is a Medicare certified other transplant center, ent	er the certif 2. Ser the certif 2. De OPO number	ication date	N			133.

Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150011 Peri od: Worksheet S-2 From 07/01/2013 Part I 06/30/2014 Date/Time Prepared: To 11/20/2014 2:46 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 145. 00 145.00 of costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient Ν services only? Enter "Y" for yes or "N" for no. 1.00 2.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146. 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 Ν 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Ν 148. 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for Ν 149.00 no. Title XIX Part A Title V Part B 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155. 00 Ν Ν 156.00 Subprovi der - IPF N N Ν N 156 00 157.00 Subprovi der - IRF Ν Ν Ν Ν 157.00 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY 160.00 N N Ν N 161.00 CMHC N Ν 161.00 Ν 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. County Zip Code CBSA FTE/Campus Name State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167.00

170.00

d168. 00

1.00169.00

Endi ng

2.00

09/30/2013

Begi nni ng

1.00

07/03/2013

167.00 s this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting

reasonable cost incurred for the HIT assets (see instructions)

transition factor. (see instructions)

period respectively (mm/dd/yyyy)

168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the

169.00|If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the

the other adjustments:

Health Financial Systems MARION GE HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet S-2 Part II Date/Time Prepared: 11/20/2014 2:46 pm Provider CCN: 150011 Peri od: From 07/01/2013 To 06/30/2014 Part A Part B Description Y/N Date Y/N 3.00 0 1.00 2.00 21.00 Was the cost report prepared only using the provider's records? If yes, see 21. 00 Ν Ν instructions.

				1. 00					
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS HOSPITALS)		1.00					
	Capital Related Cost	ETT OTTEBRENS HOST TIMES)							
	Have assets been relifed for Medicare purposes? If yes, se	e instructions			22. 00				
23. 00	Have changes occurred in the Medicare depreciation expense		g the cost		23. 00				
	reporting period? If yes, see instructions.								
24.00	Were new leases and/or amendments to existing leases enter	ed into during this cost repo	rting period?		24. 00				
	If yes, see instructions								
25. 00	Have there been new capitalized leases entered into during	the cost reporting period? I	f yes, see		25. 00				
04 00	instructions.				0, 00				
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	ne cost reporting period? IT	yes, see		26. 00				
27. 00	instructions. Has the provider's capitalization policy changed during th	a cost reporting period2 lf v	voe eubmit		27. 00				
27.00	copy.	e cost reporting perrous ir y	es, subili t		27.00				
	Interest Expense								
28. 00	Were new Loans, mortgage agreements or Letters of credit e	ntered into during the cost r	eporti na		28.00				
	period? If yes, see instructions.	3	1 3						
29. 00	Did the provider have a funded depreciation account and/or	bond funds (Debt Service Res	erve Fund)		29. 00				
	treated as a funded depreciation account? If yes, see inst								
30. 00	Has existing debt been replaced prior to its scheduled mat	urity with new debt? If yes,	see		30.00				
04 00	instructions.	6 1110.16			04.00				
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new debt? If yes,	see		31.00				
	instructions. Purchased Services								
32 00	Have changes or new agreements occurred in patient care se	rvices furnished through cont	ractual		32.00				
32.00	arrangements with suppliers of services? If yes, see instr		i actuai		32.00				
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ve bidding? If		33.00				
	no, see instructions.	, p 3 p	3						
	Provi der-Based Physi ci ans								
34.00	Are services furnished at the provider facility under an a	rrangement with provider-base	ed physi ci ans?		34. 00				
	If yes, see instructions.								
35. 00	If line 34 is yes, were there new agreements or amended ex		ovi der-based		35. 00				
	physicians during the cost reporting period? If yes, see i	nstructions.	Y/N	Date					
			1.00	2.00					
	Home Office Costs		1.00	2.00	_				
36. 00	Were home office costs claimed on the cost report?				36.00				
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the home office?			37. 00				
	If yes, see instructions.	.,,							
38.00	If line 36 is yes , was the fiscal year end of the home of	fice different from that of			38. 00				
	the provider? If yes, enter in column 2 the fiscal year en								
39. 00	If line 36 is yes, did the provider render services to oth	er chain components? If yes,			39. 00				
40.00	see instructions.	h			40.00				
40. 00	If line 36 is yes, did the provider render services to the	nome office? If yes, see			40. 00				
	i nstructi ons.								
		1.00	2	00	1				
	Cost Report Preparer Contact Information		2.						
41. 00	Enter the first name, last name and the title/position	TI NA	SEVERS		41. 00				
	held by the cost report preparer in columns 1, 2, and 3,								
	respecti vel y.								
42.00	Enter the employer/company name of the cost report	BLUE & CO., LLC			42. 00				
	preparer.								
43. 00	Enter the telephone number and email address of the cost	317-713-7946	TSEVERS@BLUEAN	DCO. COM	43. 00				
	report preparer in columns 1 and 2, respectively.				II				
	report preparer in columns 1 and 2, respectively.	1			II				

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150011 Worksheet S-2 From 07/01/2013 To 06/30/2014 Part II Date/Time Prepared: 11/20/2014 2:46 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 10/10/2014 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

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

report preparer in columns 1 and 2, respectively.

Heal th	Financial Systems MARION GENERAL H	HOSPI TAL		Non-CMS HFS Wo	rksheet
HFS Su	upplemental Information	Provi der CCN: 150011	Peri od: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part IX Date/Time Pre 11/20/2014 2:	pared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE		<u> </u>		
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Internstepdown adjustments on W/S B, Part I, column 25? Enter Y/N in and Y/N in column 2 for Title XIX.		Y	Y	1. 00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the report Part I (e.g. net of Physician's component)? Enter Y/N in colum in column 2 for Title XIX.	nn 1 for Title V and Y/N		Υ	2. 00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calcul Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for T 2 for Title XIX.			Y	3. 00
			I npati ent	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS				
4. 00	Does Title V follow Medicare (Title XVIII) for Critical Access reimbursed 101% of cost? Enter Y or N in column 1 for inpatien for outpatient.		N 2	N	4. 00
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Accereimbursed 101% of cost? Enter Y or N in column 1 for inpatien for outpatient.			N	5. 00
			Title V	Title XIX	
			1. 00	2. 00	
	RCE DI SALLOWANCE				
6. 00	Do Title V or XIX follow Medicare and add back the RCE Disallo column 4? Enter Y/N in column 1 for Title V and Y/N in column		Y	Y	6. 00
	PASS THROUGH COST				
7. 00	Do Title V or XIX follow Medicare when cost reimbursed (paymer worksheets D, parts I through IV? Enter Y/N in column 1 for Ti 2 for Title XIX.		Y	Υ	7. 00

 Heal th Financial
 Systems
 MARION

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

11/20/2014 2: I/P Days / 0/P Visits / Trips	то рііі	
Component Worksheet A No. of Beds Bed Days CAH Hours Title V		
Line Number Available		
1.00 2.00 3.00 4.00 5.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 78 28,470 0.00 0	1. 00	0
8 exclude Swing Bed, Observation Bed and		
Hospi ce 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	5. 00	
6.00 Hospital Adults & Peds. Swing Bed NF	6. 00	
7. 00 Total Adults and Peds. (exclude observation 78 28, 470 0.00 0	7. 00	U
beds) (see instructions)	8. 00	Λ
9. 00 CORONARY CARE UNIT	9. 00	
10. 00 BURN INTENSIVE CARE UNIT	10.00	
11. 00 SURGI CAL INTENSIVE CARE UNIT	11. 00	
12. 00 OTHER SPECIAL CARE (SPECIFY)	12. 00	
13. 00 NURSERY 43. 00 0	13.00	
14. 00 Total (see instructions) 43. 00 97 35, 405 0. 00 0	14. 00	
15. 00 CAH visits	15. 00	
16. 00 SUBPROVIDER - I PF 40. 00 0 0	16. 00	
17. 00 SUBPROVI DER - I IF 41. 00 18 6. 570	17. 00	
18. 00 SUBPROVI DER 42. 00 0 0	18. 00	
19. 00 SKILLED NURSING FACILITY	19. 00	
20. 00 NURSING FACILITY	20. 00	
21.00 OTHER LONG TERM CARE	21. 00	
22.00 HOME HEALTH AGENCY	22. 00	
23.00 AMBULATORY SURGICAL CENTER (D. P.)	23. 00	
24. 00 HOSPI CE	24. 00	0
24.10 HOSPICE (non-distinct part) 30.00	24. 10	
25. 00 CMHC - CMHC	25. 00	0
26.00 RURAL HEALTH CLINIC	26.00	0
26. 25 FEDERALLY QUALIFIED HEALTH CENTER	26. 25	5
27.00 Total (sum of lines 14-26) 115	27. 00	0
28.00 Observation Bed Days	28.00	0
29.00 Ambul ance Tri ps	29.00	0
30.00 Employee discount days (see instruction)	30.00	0
31.00 Employee discount days - IRF	31.00	0
32.00 Labor & delivery days (see instructions) 0 0	32.00	0
32.01 Total ancillary labor & delivery room	32. 01	1
outpatient days (see instructions)		
33.00 LTCH non-covered days	33.00	0

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part I | Date/Time Prepared: | Provider CCN: 150011

				'	0 06/30/2014	11/20/2014 2:	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E		F
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	7, 139	1, 957	14, 850		101.00	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)	2, 176	2, 753				2. 00
3.00	HMO I PF Subprovi der	o	0				3. 00
4.00	HMO IRF Subprovider	219	4				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	7, 139	1, 957	14, 850			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 830	0	3, 817			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		0	2, 209			13.00
14.00	Total (see instructions)	8, 969	1, 957	20, 876	0.00	961. 22	14.00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF	0	0	0	0.00	0.00	16. 00
17. 00	SUBPROVI DER - I RF	2, 166	98	2, 854	0.00	19. 48	17. 00
18. 00	SUBPROVI DER	0	0	0	0.00	0.00	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	980. 70	27. 00
28. 00	Observation Bed Days		1, 315	3, 574			28. 00
29. 00	Ambul ance Tri ps	1, 318					29. 00
30.00	Employee discount days (see instruction)			152			30.00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	O	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

| Peri od: | Worksheet S-3 | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared: | Health Financial Systems MARION HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 150011

				10	06/30/2014	11/20/2014 2:	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		C	1, 934	476	4, 887	1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			473	0		2.00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	C	1, 934	476	4, 887	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	C	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0. 00	C	201	9	253	17.00
18.00	SUBPROVI DER	0.00	C	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. U1	outpatient days (see instructions)						JZ. U I
33 00	LTCH non-covered days						33. 00
55.50		1		1	ı		30.00

| Period: | Worksheet S-3 | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared:

					To	06/30/2014	Date/Time Pre	pared:
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	11/20/2014 2: Average Hourly	46 pm
		Line Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	48, 785, 082	-213, 037	48, 572, 045	2, 023, 581. 00	24. 00	1. 00
	instructions)	200.00	107 7007 002	210,007	10, 0, 2, 0 10			
2. 00	Non-physician anesthetist Part		C	0	0	0. 00	0.00	2. 00
3. 00	Non-physician anesthetist Part		C	o	0	0.00	0.00	3. 00
4 00	B Bhariai an Bant A		22 4/2		22.1/2	154.00	150. 40	4 00
4. 00	Physician-Part A - Administrative		23, 162	0	23, 162	154. 00	150. 40	4. 00
4. 01	Physicians - Part A - Teaching		C	-	0	0.00	l .	
5. 00 6. 00	Physician-Part B Non-physician-Part B		C	0	0	0. 00 0. 00	l .	5. 00 6. 00
7. 00	Interns & residents (in an	21. 00	C	Ö	Ö	0.00		
7 01	approved program)					0.00	0.00	7 01
7. 01	Contracted interns and residents (in an approved		C	,	U	0.00	0.00	7. 01
	programs)		_					
8. 00 9. 00	Home office personnel	44. 00	(0	0. 00 0. 00		
10.00	Excluded area salaries (see		7, 079, 062	247, 265	7, 326, 327	413, 238. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		1, 022, 927	' 0	1, 022, 927	15, 948. 00	64. 14	11. 00
12.00	Care					0.00	0.00	10.00
12. 00	Contract labor: Top level management and other		C	0	0	0.00	0.00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		156, 140	0	156, 140	897. 00	174 07	13. 00
13.00	A - Administrative		130, 140	ĺ	130, 140	077.00	174.07	13.00
14. 00	Home office salaries & wage-related costs		C	0	0	0.00	0.00	14. 00
15. 00	Home office: Physician Part A		C	o	0	0.00	0.00	15. 00
17.00	- Administrative					0.00	0.00	17.00
16. 00	Home office and Contract Physicians Part A - Teaching		C) O	U	0.00	0.00	16. 00
	WAGE-RELATED COSTS						ı	
17. 00	Wage-related costs (core) (see instructions)		13, 075, 256	0	13, 075, 256			17. 00
18. 00	Wage-related costs (other)		C	0	0			18. 00
19. 00	(see instructions) Excluded areas		3, 558, 783	0	3, 558, 783			19. 00
20. 00	Non-physician anesthetist Part		3, 330, 703	o o	0, 330, 703			20.00
21 00	A							21 00
21. 00	Non-physician anesthetist Part B		C) O	U			21. 00
22. 00	Physician Part A -		C	o	0			22. 00
22. 01	Administrative Physician Part A - Teaching		(0			22. 01
23. 00	Physician Part B		Č	o	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		C	1	0			24. 00 25. 00
25.00	approved program)			,	O			25.00
27.00	OVERHEAD COSTS - DIRECT SALARIE	4. 00	917, 477	29, 165	946, 642	22 224 00	29. 37	26. 00
26. 00 27. 00	Employee Benefits Department Administrative & General	5. 00	7, 691, 857		7, 427, 484	32, 236. 00 316, 145. 00		
28. 00	Administrative & General under		1, 824, 536		1, 824, 536	11, 216. 00		28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	C		0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	482, 597	-19, 480	463, 117	28, 514. 00		
31.00	Laundry & Linen Service	8. 00	C	0	0	0.00		
32. 00 33. 00	Housekeeping under contract	9. 00	1, 369, 024	. 0	1, 369, 024	0. 00 107, 120. 00		
	(see instructions)		,		,			
34. 00 35. 00	Dietary Dietary under contract (see	10. 00	1, 286, 633	0	0 1, 286, 633	0. 00 69, 448. 00		
	instructions)		1, 200, 033		1, 200, 033			
36.00	Cafeteria	11. 00	C	0	0	0.00	l .	
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	1, 383, 034	0 -541, 178	841, 856	0. 00 23, 588. 00	l .	37. 00 38. 00
39. 00	Central Services and Supply	14. 00	216, 791	18, 653	235, 444	14, 369. 00	16. 39	39. 00
40. 00	Pharmacy	15. 00	2, 291, 723	-5, 528	2, 286, 195	56, 632. 00	40. 37	40. 00

Health Financial Systems		MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 07/01/2013		
					To 06/30/2014		
						11/20/2014 2:	46 pm_
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	C	0		0.00	0.00	41. 00
Records Library							
42.00 Social Service	17. 00	C	0		0.00	0.00	42.00
43.00 Other General Service	18. 00	C	0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150011 Peri od: From 07/01/2013 To 06/30/2014 11/20/2014 2:46 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 53, 265, 275 -213, 037 53, 052, 238 2, 211, 365. 00 23. 99 1.00 instructions) 2.00 7, 079, 062 247, 265 7, 326, 327 413, 238. 00 17. 73 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 46, 186, 213 -460, 302 45, 725, 911 1, 798, 127. 00 25.43 3.00 minus line 2) 4.00 Subtotal other wages & related 1, 179, 067 1, 179, 067 16, 845. 00 70.00 4.00 costs (see inst.) Subtotal wage-related costs 5.00 13, 075, 256 Ω 13, 075, 256 0.00 28.59 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 60, 440, 536 -460, 302 59, 980, 234 1, 814, 972. 00 33. 05

17, 463, 672

-782, 741

16, 680, 931

659, 268. 00

25. 30

7.00

7.00

Total overhead cost (see

instructions)

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 150011	Period: Worksheet S-3 From 07/01/2013 Part IV
		To 06/30/2014 Date/Time Prepared:

	To 06/30/2014	Date/Time Prep 11/20/2014 2:4	
		Amount Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 130, 292	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2, 204, 914	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	112, 179	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	7, 841, 027	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	1, 417	
11. 00	Life Insurance (If employee is owner or beneficiary)	49, 135	
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	508, 491	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		529, 814	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	4, 029, 769	
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	11, 215	
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER	_	
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
00.00	instructions))		00.00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	151, 880	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	16, 570, 133	24. 00
25 62	Part B - Other than Core Related Cost	(2.00)	25 00
25.00	EMPLOYEE RELATIONS AND OTHER	63, 906	25.00

Hoal th	Financial Systems	MARION GENERAL H	∩SDI TAI		Inlie	u of Form CMS-:	2552_10
	AL CONTRACT LABOR AND BENEFIT COST	WARTON GENERAL IN		CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part V	pared:
	Cost Center Description				Contract Labor		
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital -Based Component Identi				_	_	
1.00	Total facility's contract labor and benefit	cost			0	0	1. 00
2.00	Hospi tal				0	0	
3.00	Subprovi der - I PF				0	0	3.00
4.00	Subprovi der - I RF				0	0	
5.00	Subprovider - (Other)				0	0	
6.00	Swing Beds - SNF				0	0	6. 00
7.00	Swing Beds - NF				0	0	7. 00
8.00	Hospi tal -Based SNF						8. 00
9.00	Hospi tal -Based NF						9. 00
10.00	Hospi tal -Based OLTC						10.00
11. 00	Hospi tal -Based HHA						11. 00
12. 00	Separately Certified ASC						12.00
13. 00	Hospi tal -Based Hospi ce						13.00
14. 00	Hospital-Based Health Clinic RHC						14. 00
15. 00	Hospital-Based Health Clinic FQHC						15. 00
	Hospi tal -Based-CMHC						16. 00
17. 00	Renal Dialysis						17. 00
18. 00	Other				0	0	18. 00

Hool +h	Financial Systems MARION GENERAL HO	CDI TAI		la li a	eu of Form CMS-2	DEE2 10					
	Financial Systems MARION GENERAL HOTAL UNCOMPENSATED AND INDIGENT CARE DATA		CCN: 150011	Period:	Worksheet S-1						
позыт	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider	CCN. 130011	From 07/01/2013		J					
				To 06/30/2014		oared:					
					11/20/2014 2:	46 pm					
					1. 00						
	Uncompensated and indigent care cost computation					1. 00					
1. 00	j										
	Medicaid (see instructions for each line)										
2.00	Net revenue from Medicaid				16, 077, 307	2. 00					
3.00	Did you receive DSH or supplemental payments from Medicaid?			10		3. 00					
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental		from Medicai	ď?		4. 00					
5.00	If line 4 is "no", then enter DSH or supplemental payments from	меагсага			0	5. 00					
6.00	Medicaid charges				55, 625, 079	6. 00					
7.00	Medicaid cost (line 1 times line 6)	7	6 1!	0 1 5 . 1 6	16, 511, 526	7. 00					
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	line / mir	ius sum of II	nes 2 and 5; IT	434, 219	8. 00					
	State Children's Health Insurance Program (SCHIP) (see instruct	ions for (ach Lino)								
9. 00	Net revenue from stand-alone SCHIP	10115 101 6	each Tine)		0	9. 00					
10.00	Stand-alone SCHIP charges				0	9. 00 10. 00					
11. 00	Stand-alone SCHIP cost (line 1 times line 10)					10.00					
12. 00	Difference between net revenue and costs for stand-alone SCHIP	(lino 11 r	ninus lina O	if a zoro thon		12.00					
12.00	enter zero)	(Tine III	iiinus iine 9;	ii < Zero then	U	12.00					
	Other state or local government indigent care program (see inst	ructions 1	or each line)							
13. 00	Net revenue from state or local indigent care program (Not incl				0	13. 00					
14. 00	Charges for patients covered under state or local indigent care					14. 00					
14.00	10)	pi ogi alli	(NOT THE due	THE THES O OF		14.00					
15. 00	State or local indigent care program cost (line 1 times line 14)			o	15. 00					
16. 00	Difference between net revenue and costs for state or local ind		e program (Li	ne 15 minus line	0	16. 00					
	13; if < zero then enter zero)	. goirt our	, p. 09. a (
	Uncompensated care (see instructions for each line)										
17.00	Private grants, donations, or endowment income restricted to fu	ndi ng chai	rity care		0	17. 00					
18.00	Government grants, appropriations or transfers for support of h	ospital o	perati ons		0	18. 00					
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and Loca	I indigen	t care progra	ms (sum of lines	434, 219	19. 00					
	8, 12 and 16)	· ·	. 0	·							
			Uni nsured	Insured	Total (col. 1						
			pati ents	pati ents	+ col . 2)						
			1.00	2. 00	3. 00						
20. 00	Total initial obligation of patients approved for charity care		21, 071, 1	05 44, 542, 088	65, 613, 193	20. 00					
	charges excluding non-reimbursable cost centers) for the entire				10 17/						
21. 00	Cost of initial obligation of patients approved for charity car	e (line 1	6, 254, 6	63 13, 221, 695	19, 476, 358	21. 00					
00.00	times line 20)		104.6	45 070 044	45 0/0 000	00.00					
22. 00	Partial payment by patients approved for charity care		181, 2								
23.00	Cost of charity care (line 21 minus line 22)		6, 073, 4	08 -1, 857, 349	4, 216, 059	23. 00					
					1. 00						
24. 00	Does the amount in line 20 column 2 include charges for patient	davs bevo	ond a Length	of stav limit	N	24. 00					
	imposed on patients covered by Medicaid or other indigent care		3	y							
25. 00	If line 24 is "yes," charges for patient days beyond an indige		rogram's Lend	th of stay limit	0	25. 00					
26. 00	Total bad debt expense for the entire hospital complex (see ins			,	12, 902, 303	26. 00					
27. 00	Medicare bad debts for the entire hospital complex (see instruc				462, 429						
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (li		us line 27)		12, 439, 874						
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp			e 28)	3, 692, 602						
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	•		•	7, 908, 661						
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			8, 342, 880						
	· · · · · · · · · · · · · · · · · · ·	•				•					

	FINANCIAL SYSTEMS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARIUN GENERAL		CCN: 1E0011 F	Peri od:	Worksheet A	2552-10
RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider		rom 07/01/2013		
					o 06/30/2014	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	11/20/2014 2: Recl assi fi ed	46 pm
	cost center bescription	Sararres	Other	+ col . 2)		Tri al Balance	
				,	, ,	(col. 3 +-	
						col . 4)	
	[1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		12 000 112	12 000 112	1 204 702	11 402 221	1 1 00
1. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	917, 477	12, 800, 113 17, 010, 897	12, 800, 113 17, 928, 374		11, 403, 321 17, 985, 520	1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	7, 691, 857	21, 383, 537	29, 075, 394		28, 953, 431	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	27,070,070	0	0	6.00
6. 01	00601 CAFETERI A	0	O	C	1, 261, 931	1, 261, 931	6. 01
6.02	00602 CAFETERI A	0	0	C	0	0	6. 02
7.00	00700 OPERATION OF PLANT	482, 597	3, 458, 229	3, 940, 826		4, 303, 035	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	384, 274 2, 411, 501	384, 274 2, 411, 501		384, 274 2, 420, 200	8. 00 9. 00
10. 00	01000 DI ETARY		1, 929, 431	1, 929, 431		599, 644	10.00
13. 00	01300 NURSING ADMINISTRATION	1, 383, 034	29, 070	1, 412, 104		870, 926	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	216, 791	499, 605	716, 396		735, 049	14. 00
15.00	01500 PHARMACY	2, 291, 723	6, 842, 304	9, 134, 027	-6, 372, 733	2, 761, 294	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00	03000 ADULTS & PEDI ATRI CS	8, 865, 957	1, 129, 075	9, 995, 032	· ·	9, 106, 060	30.00
31. 00	03100 I NTENSI VE CARE UNI T	2, 545, 078	312, 311	2, 857, 389	-29, 683	2, 827, 706	31.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	993, 258	752, 896	1 7/4 15/		0 1, 746, 154	40. 00 41. 00
41.00	04200 SUBPROVI DER	993, 236	752, 690	1, 746, 154 C		1, 740, 134	41.00
43. 00	04300 NURSERY	0	Ö	C	1 1	1, 067, 090	43.00
	ANCILLARY SERVICE COST CENTERS	-1	-1		1, 221, 212	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
50.00	05000 OPERATING ROOM	3, 009, 850	4, 583, 626	7, 593, 476	283, 891	7, 877, 367	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 901, 036	2, 493, 034	5, 394, 070	· ·	4, 576, 331	54.00
57. 00	05700 CT SCAN	0	0	C	820, 485	820, 485	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	F2(412)	0 (57 0(1	2 104 272	480, 303	480, 303	58. 00 59. 00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	526, 412 2, 662, 126	2, 657, 961 4, 367, 516	3, 184, 373 7, 029, 642		3, 231, 014 6, 935, 261	
60. 01	06001 ONCOLOGY	958, 933	490, 038	1, 448, 971		1, 448, 971	
60. 02	06002 RADIATION ONCOLOGY	0	0	.,,	1	0	60. 02
65.00	06500 RESPI RATORY THERAPY	1, 192, 280	669, 648	1, 861, 928	86, 589	1, 948, 517	65.00
66.00	06600 PHYSI CAL THERAPY	1, 428, 673	525, 536	1, 954, 209	1	1, 954, 209	66. 00
69. 00	06900 ELECTROCARDI OLOGY	650, 331	87, 836	738, 167		820, 626	69. 00
69. 01	06901 CARDI AC REHAB	96, 702	6, 974	103, 676	30, 252	133, 928	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		6, 372, 733	6, 372, 733	73.00
	OUTPATIENT SERVICE COST CENTERS	-1	-,	-	2/ 2/ 2/ 2/	27 01 27 1 22	
90.00	09000 CLI NI C	169, 437	88, 037	257, 474	60, 961	318, 435	90.00
91. 00	09100 EMERGENCY	3, 715, 726	936, 145	4, 651, 871	-43, 439	4, 608, 432	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0)	0	92. 01
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	830, 928	132, 952	963, 880	33, 786	997, 666	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	030, 720	132, 732	703, 000	33, 700	777,000	75.00
113.00	11300 INTEREST EXPENSE		0	C	0	0	113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	43, 530, 206	85, 982, 546	129, 512, 752	-562, 839	128, 949, 913	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 836	13, 836		33, 674	
	19200 PHYSI CLANS' PRI VATE OFFI CES 19202 VISITOR MEALS	0	0	C			192. 00 192. 02
192.02		1 ()	U	· ·	y Y		
		1 -1	705	125 200	1 4071		1102 O2
192. 03	19203 GREAT BEGINNINGS/MATERNAL	124, 685	705 0	125, 390	4, 687		
192. 03 192. 04	19203 GREAT BEGINNI NGS/MATERNAL 19204 LI FELI NE	1 -1	o	C	0	0	192. 04
192. 03 192. 04 192. 05	19203 GREAT BEGINNINGS/MATERNAL	124, 685	705 0 993, 451 20, 965	125, 390 0 993, 451 50, 168	0 -434, 069		192. 04 192. 05
192. 03 192. 04 192. 05 192. 08 192. 09	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT	124, 685 0 0	0 993, 451	993, 451	0 -434, 069 13, 493	0 559, 382 63, 661 44, 549	192. 04 192. 05 192. 08 192. 09
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS	124, 685 0 0 29, 203 0	0 993, 451 20, 965 25, 069 1, 201	993, 451 50, 168 25, 069 1, 201	0 -434, 069 3 13, 493 19, 480 1, 172	0 559, 382 63, 661 44, 549 2, 373	192. 04 192. 05 192. 08 192. 09 192. 10
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT	124, 685 0 0 29, 203 0 0 1, 044, 634	0 993, 451 20, 965 25, 069 1, 201 382, 499	993, 451 50, 168 25, 069 1, 201 1, 427, 133	0 -434, 069 13, 493 19, 480 1, 172 44, 652	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081 0 328, 665	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236 126, 717	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523 385, 247	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759 511, 964	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081 0 328, 665	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081 0 328, 665	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964 906, 977	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 15 192. 15 192. 17 192. 18 192. 19	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236 126, 717 256, 690	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523 385, 247 572, 146	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759 511, 964 828, 836	0 -434, 069 13, 493 19, 480 1,172 44, 652 30, 081 0 328, 665 0 78, 141	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964 906, 977	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236 126, 717 256, 690 0 202, 477 179, 200	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523 385, 247 572, 146 0 548, 579 617, 450	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759 511, 964 828, 836 751, 056	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081 0 328, 665 0 78, 141 0 0 1, 239 2, 133	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964 906, 977 0 752, 295 798, 783	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 193. 00 193. 01 193. 02	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236 126, 717 256, 690 0 202, 477 179, 200 32, 189	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523 385, 247 572, 146 0 548, 579 617, 450 2, 452, 012	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759 511, 964 828, 836 751, 056 796, 650 2, 484, 201	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081 0 328, 665 0 78, 141 0 0 1, 239 2, 133	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964 906, 977 0 752, 295 798, 783 2, 484, 201	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01 193. 02 193. 03
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 17 192. 18 192. 19 193. 00 193. 01 193. 01 193. 03	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236 126, 717 256, 690 0 202, 477 179, 200 32, 189 691, 957	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523 385, 247 572, 146 0 548, 579 617, 450 2, 452, 012 1, 388, 750	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759 511, 964 828, 836 0 751, 056 796, 650 2, 484, 201 2, 080, 707	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081 0 328, 665 0 78, 141 0 0 1, 239 2, 133 0	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964 906, 977 0 752, 295 798, 783 2, 484, 201 2, 080, 707	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 193. 00 193. 01 193. 02 193. 03 193. 04
192. 03 192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 193. 00 193. 01 193. 02 193. 03 193. 04 193. 05	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MGH MGH ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC MSPITALISTS 19304 MGH MAR FAM PRACT 19305 MGH FMC SWAYZEE	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236 126, 717 256, 690 0 202, 477 179, 200 32, 189 691, 957 49, 255	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523 385, 247 572, 146 0 548, 579 617, 450 2, 452, 012 1, 388, 750 103, 910	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759 511, 964 828, 836 0 751, 056 796, 650 2, 484, 201 2, 080, 707 153, 165	0 -434, 069 13, 493 19, 480 1, 172 44, 652 30, 081 0 328, 665 0 78, 141 0 1, 239 2, 133 0 0 24, 989	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964 906, 977 0 752, 295 798, 783 2, 484, 201 2, 080, 707 178, 154	192. 04 192. 05 192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 193. 00 193. 01 193. 02 193. 04 193. 04 193. 05
192. 03 192. 04 192. 05 192. 08 192. 09 192. 14 192. 15 192. 16 192. 17 192. 18 193. 00 193. 01 193. 02 193. 03 193. 05 193. 05	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	124, 685 0 0 29, 203 0 0 1, 044, 634 336, 376 0 605, 236 126, 717 256, 690 0 202, 477 179, 200 32, 189 691, 957	0 993, 451 20, 965 25, 069 1, 201 382, 499 1, 675, 480 959, 621 1, 533, 523 385, 247 572, 146 0 548, 579 617, 450 2, 452, 012 1, 388, 750	993, 451 50, 168 25, 069 1, 201 1, 427, 133 2, 011, 856 959, 621 2, 138, 759 511, 964 828, 836 751, 056 796, 650 2, 484, 201 2, 080, 707 153, 165	0 -434, 069 13, 493 19, 480 1,172 44, 652 30, 081 0 328, 665 0 78, 141 0 1, 239 2, 133 0 0 24, 989 39, 960	0 559, 382 63, 661 44, 549 2, 373 1, 471, 785 2, 041, 937 959, 621 2, 467, 424 511, 964 906, 977 0 752, 295 798, 783 2, 484, 201 2, 080, 707	192. 08 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01 193. 02 193. 03 193. 05 193. 05 193. 05

Health Financial Systems	MARION GENERA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der		Period: From 07/01/2013	Worksheet A	
				Γο 06/30/2014		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
193. 08 19308 MGH FMC CONVERSE	73, 542	153, 810	227, 352		227, 352	1
193.09 19309 MGH UPLAND HEALTH	362, 709	761, 832	1, 124, 54	6, 345	1, 130, 886	193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0	(0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	64, 723	438, 294	503, 01	13, 977	516, 994	193. 11
193. 12 19312 OB/GYN	421, 477	1, 772, 818	2, 194, 29	12, 783	2, 207, 078	193. 12
193. 15 19315 MGH RIVER VIEW BLDG	0	0	(0	0	193. 15
194. 00 07963 OTHER NONREI MBURSABLE	0	0	(0	0	194. 00
194. 01 07950 MOW	0	0	(0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	0	(0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	(305, 477	305, 477	194. 03
194. 04 07953 MGH WORK SOLUTIONS	315, 316	503, 904	819, 220	11, 074	830, 294	194. 04
194. 05 07954 MGH TAYLOR UNIVERSITY	49, 430	101, 406	150, 830	5 0	150, 836	194. 05
194.08 07957 MGH SMMP BLDG	0	258, 587	258, 58	7 0	258, 587	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	59, 878	59, 878	0	59, 878	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	11, 272	11, 27:	2 0	11, 272	194. 10
200.00 TOTAL (SUM OF LINES 118-199)	48, 785, 082	102, 739, 889	151, 524, 97 ⁻	1 0	151, 524, 971	200. 00

			To 06/30/2014 Date/lime F	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-196, 392			1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 346, 292			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS	-12, 444, 356 0	16, 509, 075		5. 00 6. 00
6. 01 00601 CAFETERI A	-31, 722	1, 230, 209		6. 01
6. 02 00602 CAFETERI A	0	0		6. 02
7.00 OO700 OPERATION OF PLANT	-134, 703	4, 168, 332		7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	-6, 855			8. 00 9. 00
10. 00 01000 DI ETARY	-1, 619 -5, 670	2, 418, 581 593, 974		10.00
13. 00 01300 NURSING ADMINISTRATION	-58	870, 868		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	-902	734, 147		14. 00
15. 00 01500 PHARMACY	-27, 309	2, 733, 985		15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	-32, 711	9, 073, 349		30.00
31. 00 03100 NTENSI VE CARE UNIT	-52,711	2, 827, 118		31.00
40. 00 04000 SUBPROVI DER - PF	0	0		40. 00
41. 00 04100 SUBPROVI DER - I RF	-85, 030	1, 661, 124		41. 00
42. 00 04200 SUBPROVI DER	0	0		42.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	1, 067, 090		43. 00
50. 00 05000 OPERATING ROOM	-17, 435	7, 859, 932		50.00
51. 00 05100 RECOVERY ROOM	0	0		51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-351, 066	4, 225, 265		54.00
57. 00 05700 CT SCAN	0	820, 485		57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0 -31, 733	480, 303 3, 199, 281		58. 00 59. 00
60. 00 06000 LABORATORY	-47, 189			60.00
60. 01 06001 0NCOLOGY	-1, 021	1, 447, 950		60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		60. 02
65. 00 06500 RESPIRATORY THERAPY	-12, 161	1, 936, 356		65. 00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	-83 -53, 691	1, 954, 126 766, 935		66. 00 69. 00
69. 01 06901 CARDI AC REHAB	-11	133, 917		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	-800	6, 371, 933		73. 00
90. 00 09000 CLINIC	-215	318, 220		90.00
91. 00 09100 EMERGENCY	-166, 262	4, 442, 170		91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0		92. 01
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	-78, 518	919, 148		95. 00
SPECIAL PURPOSE COST CENTERS	70,010	717,110		70.00
113. 00 11300 INTEREST EXPENSE	0			113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-15, 074, 392	113, 875, 521		118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33, 674		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	· · · · · · · · · · · · · · · · · · ·		192.00
192.02 19202 VISITOR MEALS	0	0		192. 02
192. 03 19203 GREAT BEGINNI NGS/MATERNAL	0	130, 077		192. 03
192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES	0	559, 382		192. 04 192. 05
192. 08 19211 PARI SH NURSI NG	0	63, 661		192. 03
192. 09 19212 BI OTERRORI SM GRANT	Ö	44, 549		192. 09
192.10 19214 BREAST PUMPS	0	2, 373		192. 10
192. 14 19210 MGH PHYS PRACT MGMT	-61, 392	1, 410, 393		192. 14
192. 15 19215 MGH MARION SURGEONS 192. 16 19216 MGH MGH MED ONC	0	2, 041, 937 959, 621		192. 15 192. 16
192. 17 19217 MGH FMC SOUTH	-315, 532	2, 151, 892		192. 10
192. 18 19218 MGH FAIRM MED ASSOC	0	511, 964		192. 18
192.19 19219 MGH FMC MARION	-114, 317	792, 660		192. 19
193. 00 19300 NONPALD WORKERS	0	752 205		193. 00
193.01 19301 MGH FMC NORTHWOOD 193.02 19302 MGH FMC GAS CITY	0	752, 295 798, 783		193. 01 193. 02
193. 02 19302 MGH FMC GAS CTTY 193. 03 19303 MGH HOSPI TALI STS	0	2, 484, 201		193. 02
193. 04 19304 MGH MAR FAM PRACT	Ö	2, 080, 707		193. 04
193.05 19305 MGH FMC SWAYZEE	-28, 175			193. 05
193. 06 19306 MGH PEDIATRIC CTR	-61, 648			193. 06
193. 07 19307 MGH SPECIALTY PHYS 193. 08 19308 MGH FMC CONVERSE	-41, 632 0	299, 613 227, 352		193. 07 193. 08
193. 09 19309 MGH UPLAND HEALTH	0			193. 00
	,			-

 Health Financial
 Systems
 MARION GE

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

Period: Worksheet A From 07/01/2013 To 06/30/2014 Date/Time Prepared: 11/20/2014 2:46 pm

			11/20/2014 2: 46 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7. 00	
193. 10 19310 MGH MGH WOMENS CTR	0	0	193. 10
193. 11 19311 MGH MGH PSYCHLATRY	-18, 872	498, 122	193. 11
193. 12 19312 OB/GYN	0	2, 207, 078	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	194. 00
194. 01 07950 MOW	0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	305, 477	194. 03
194.04 07953 MGH WORK SOLUTIONS	-101, 516	728, 778	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	150, 836	194. 05
194.08 07957 MGH SMMP BLDG	0	258, 587	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	59, 878	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	11, 272	194. 10
200.00 TOTAL (SUM OF LINES 118-199)	-15, 817, 476	135, 707, 495	[200. 00

Health Financial Systems
COST CENTERS USED IN COST REPORT In Lieu of Form CMS-2552-10
Worksheet Non-CMS W Provi der CCN: 150011 | Peri od: | Worksheet Non-CMS W | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared:

Cost Center Description			То	06/30/2014 Date/Time P 11/20/2014 :	
CERHANL SERVICE COST CENTERS 1.00 2.00		Cost Center Description	CMS Code	Standard Label For	21 10 p
Filterant Strivice Dest Centress				Non-Standard Codes	
Filterant Strivice Dest Centress					
New CAP REL COSTS-BLUGG A FIXT		OFFICE ALL OFFICE AND ADDRESS OF A PRITE PO	1.00	2. 00	
ADDITIONAL SUPPLIES BENEFIT SEPARIMENT 0.0400 5.00 5.00 6.00	1 00		00100		1 00
MAINTENANCE & REPAIRS 00001					11
0 OC CAFFERN A	5.00		00500		5. 00
CAPETERIA CO0000					11
7.00 OPERATION OF PLANT COMBOD R. 0.0000 R. 0.00000 R. 0.00000 R. 0.00000 R. 0.00000 R. 0.000000 R. 0.0000000 R. 0.0000000000					11
8.00 LAURDEY & LINES SERVICE 0.0000 9.00					11
10.00 IEFARY 0.000 10.00 11.00 11.30 11.30 11.40 11.					11
13.00 MIRSTRA ZMAN INSTRATION 0.1300 13.00 1					11
14.00 CENTRAL SERVICES & SUPPLY D1500					11
15.00					11
30.00 ADULTS & PEDIATRICS 03000 30.00 31.00					11
11.00 INTENSIVE CARE UNIT					
40.00 SUBPROVIDER - IPF					11
1.00 SUBPROVIDER O4100 41.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 43.00 42.00 43.00					- 11
42.00 SUPPROVIDER					11
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50.00 OPERATI INC ROOM	43.00		04300		43. 00
51.00 RECOVERY ROOM	EO 00		05000		F0 00
54. 00 RADI OLOGY - DI AGNOSTI C S. 0. 00 S. 0. 00 S. 0. 00 S. 0. 00 MACRITI C RESONANCE IMAGING (MRI) 0.5800 0.5800 5.5. 0. 00 S. 0. 00 MACRITI C RESONANCE IMAGING (MRI) 0.5900 0.5900 5.5. 0. 00 S. 0. 00 0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000					11
57.00 CT SCAN 05700 55.00 55					11
59.00 CARDI AC CATHETERI ZATI ON 550.00 65.00 60.00 65.00	57.00		05700		57. 00
60.00 LABORATORY 06000 60.00		, ,			11
60 01 00COLOGY 06001 60 01					- 11
0.0.02 RADIATION ONCOLOGY 0.0.02					- 11
66.00 PHYSICAL THERAPY 06600 69.00 6					11
69 00 ELECTROCARDIOLOGY 69 00 69 00 69 00 69 01					11
69. 01 CARDIAC REHAB 0.6901 0.6901 0.71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00					- 11
17. 00 MEDI CAL, SUPPLIES CHARGED TO PATIENTS 0.7100 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 0.7300 73. 00 0.7300 73. 00 0.7300 73. 00 0.7300 0.7300 73. 00 0.730					11
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91. 00 MERGENCY 09100 991. 00 92. 00 93. 00 9	90 00		09000		90,00
92. 01 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 95. 00 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1-117) NONNER MBURSABLE COST CENTERS 190. 00 GFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 PHYSI CLANS' PRI VATE OFFICES 192. 01 PHYSI CLANS' PRI VATE OFFICES 192. 02 VI SI TOR MEALS 192. 03 GREAT BEGINNI NGS/MATERNAL 192. 04 LI FELI NE 192. 05 UNIDED PROPERTIES 192. 06 PARI SH NURSI NG 192. 09 BI OTERRORI SM GRANT 192. 01 DISBEAST PUMPS 192. 10 BREAST PUMPS 192. 10 BREAST PUMPS 192. 10 MICH PROPERTIES 192. 10 MICH PHYS PRACT INGMT 192. 11 MICH PHYS PRACT INGMT 192. 15 MICH MARI ON SURGEONS 192. 16 192. 17 MICH FMC SOUTH 192. 18 192. 18 192. 19 193. 00 NONPAL D WORKERS 193. 01 193. 01 193. 01 193. 02 MICH FMC MARI ON 193. 03 193. 04 194. 04 195. 05 196. 06 197. 06 197. 07 197.					
OTHER REIMBURSABLE COST CENTERS 95.00 95					- 11
95. 00 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1-117) 118. 00 NONERIMBURSABLE COST CENTERS 1190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 02 VISI TOR MEALS 192. 03 GREAT BEGINNI NGS/MATERNAL 192. 03 GREAT BEGINNI NGS/MATERNAL 192. 04 LIFELI NE 192. 05 OWNED PROPERTIES 192. 05 OWNED PROPERTIES 192. 06 PARI SH NURSI NG 192. 10 BEARST PUMPS 192. 10 BREAST PUMPS 192. 10 BREAST PUMPS 192. 11 MGH PHYS PRACT MGMT 192. 15 MGH MARI ON SURGEONS 192. 16 MGH MGH MD SURCEONS 192. 16 MGH MGH MD SURCEONS 192. 17 MGH FMC SOUTH 192. 18 MGH FAI RM MED ASSOC 193. 00 NONPAID MORKERS 193. 01 MGH FMC NORTHWOOD 193. 00 NONPAID MORKERS 193. 01 MGH FMC NORTHWOOD 193. 00 NONPAID MORKERS 193. 03 MGH HOSPITALISTS 193. 03 MGH HOSPITALISTS 193. 04 MGH MAR PAN PRACT 193. 05 MGH HEC SWAYZEE 193. 06 MGH PEDIATRIC CTR 193. 06 MGH PEDIATRIC CTR	92. 01		09201		92. 01
SPECIAL PURPOSE COST CENTERS	05 00		00500		05.00
113.00 NTEREST EXPENSE 11300 118.00 11	73.00		09300		95.00
NONREIMBURSABLE COST CENTERS 190.00 190.00 190.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.02 192.03 192.03 192.03 192.03 192.03 192.04 192.05 192.05 192.05 192.05 192.05 192.05 192.05 192.05 192.06 192.05 192.06 192.07 192.08 192.08 192.08 192.11 192.08 192.10 192.09 192.10 192.10 192.10 192.11 192.08 192.11 192.09 192.14 192.15 192.15 192.15 192.16 192.16 192.17 192.18 192.17 192.18 192.17 192.18 192.17 192.18 192.17 192.18 192.19	113.00		11300		113. 00
190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19000 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 03 192. 03 192. 03 192. 04 192. 04 192. 05 192. 06 192. 07 192. 10 192. 10 192. 10 192. 10 192. 14 192. 10 192. 14 192. 10 192. 14 192. 10 192. 15 192. 16 192. 16 192. 16 192. 16 192. 16 192. 16 192. 17 192. 17 192. 18 192. 19 192. 19 192. 19 192. 19 193. 00 193. 01 193. 01 193. 01 193. 01 193. 01 193. 01 193. 02 193. 03 193. 04 194. 16 193. 05 193. 05 193. 06 194. 16 193. 06 194. 16 193. 06 193. 06 194. 16 193. 06 193. 06 194. 16 193. 06 193. 06 194. 16 193. 06 193. 06 194. 16 193. 06 193. 06 193. 06 194. 16 193. 06 193. 06 193. 06 194. 16 193. 06	118.00				118. 00
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192. 05 OWNED PROPERTIES 192. 08 PARI SH NURSI NG 192. 09 BI OTERRORI SM GRANT 192. 10 BREAST PUMPS 192. 11 MGH PHYS PRACT MGMT 192. 12 MGH MARI ON SURGEONS 192. 15 MGH MGH MED ONC 192. 16 MGH MGH MED ONC 192. 17 MGH FMC SOUTH 192. 18 MGH FAIRM MED ASSOC 192. 19 MGH FAIRM MED ASSOC 192. 19 MGH FMC MARI ON 192. 19 MGH FMC MARI ON 193. 00 NONPAI D WORKERS 193. 00 NONPAI D WORKERS 193. 00 MGH FMC SOITY 193. 00 MGH MGH MGR MGH MGH MGH MGH 193. 00 MGH FMC MARI ON 193. 01 MGH FMC NORTHWOOD 193. 02 MGH FMC GAS CITY 193. 03 MGH HOSPITALISTS 193. 04 MGH MAR FAM PRACT 193. 05 MGH FMC SWAYZEE 193. 06 MGH PEDIATRIC CTR	192. 03	GREAT BEGINNINGS/MATERNAL	19203		
192. 08 PARI SH NURSI NG 192. 09 BI OTERRORI SM GRANT 192. 10 BREAST PUMPS 192. 10 BREAST PUMPS 192. 14 MGH PHYS PRACT MGMT 192. 15 MGH MARI ON SURGEONS 192. 16 MGH MGH MED ONC 192. 17 MGH FMC SOUTH 192. 17 MGH FMC SOUTH 192. 18 MGH FAI RM MED ASSOC 192. 19 MGH FAI RM MED ASSOC 192. 19 MGH FMC MARI ON 192. 19 MGH FMC NORTHWOOD 193. 01 MGH FMC NORTHWOOD 193. 01 MGH FMC NORTHWOOD 193. 02 MGH FMC GAS CITY 193. 03 MGH HOSPI TALI STS 193. 04 MGH MAR FAM PRACT 193. 05 MGH FMC SWAYZEE 193. 06 MGH PEDI ATRI C CTR					
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193. 01 MGH FMC NORTHWOOD 193.01 193. 02 MGH FMC GAS CITY 193.02 193. 03 MGH HOSPI TALI STS 19303 193. 04 MGH MAR FAM PRACT 19304 193. 05 MGH FMC SWAYZEE 19305 193. 06 MGH PEDI ATRI C CTR 19306					- 11
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193. 03 MGH HOSPI TALI STS 19303 193. 03 193. 04 MGH MAR FAM PRACT 19304 193. 04 193. 05 MGH FMC SWAYZEE 19305 193. 05 193. 06 MGH PEDIATRIC CTR 19306 193. 06					
193. 04 MGH MAR FAM PRACT 19304 193. 04 193. 05 MGH FMC SWAYZEE 19305 193. 05 193. 06 MGH PEDIATRIC CTR 19306 193. 06					
193.06 MGH PEDIATRIC CTR 19306 193.06	193. 04	MGH MAR FAM PRACT	19304		193. 04
175. O/ 1750/ 1750/ 175. U/					
	. 73. 07	1	17307		1175.07

GENERAL HOSPI TAL	in Lie	u of Form CMS-2552-10
Provi der CCN: 150011		Worksheet Non-CMS W
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		10 06/30/2014 Date/IIme 11/20/2014	
Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
193. 08 MGH FMC CONVERSE	19308		193. 08
193.09 MGH UPLAND HEALTH	19309		193. 09
193. 10 MGH MGH WOMENS CTR	19310		193. 10
193. 11 MGH MGH PSYCHIATRY	19311		193. 11
193. 12 OB/GYN	19312		193. 12
193.15 MGH RIVER VIEW BLDG	19315		193. 15
194.00 OTHER NONREIMBURSABLE	07963		194. 00
194. 01 MOW	07950		194. 01
194. 02 MENTAL HEALTH	07951		194. 02
194. 03 ADVERTI SI NG	07952		194. 03
194. 04 MGH WORK SOLUTIONS	07953		194. 04
194. 05 MGH TAYLOR UNIVERSITY	07954		194. 05
194.08 MGH SMMP BLDG	07957		194. 08
194.09 MGH AMBUCARE BLDG	07958		194. 09
194.10 MGH 106 LYONS BLDG	07959		194. 10
200.00 TOTAL (SUM OF LINES 118-199)			200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 07/01/2013 To 06/30/2014 Date/Time Prepared: Provider CCN: 150011

					/20/2014 2:46 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2.00	3. 00	4. 00	5. 00	
1 00	A - SATELITE OFFICE	(0.00	4 074	2 122	1.00
1.00	ELECTROCARDI OLOGY	69. 00 54. 00	4, 974	2, 123	1.00
2. 00	RADI OLOGY-DI AGNOSTI C TOTALS		12 <u>9, 2</u> 53 134, 227	2 <u>2, 0</u> 68 24, 191	2. 00
	B - CAFETERIA		134, 227	24, 171	
1.00	ADMI NI STRATI VE & GENERAL	5. 00	O	95, 270	1.00
2. 00	CAFETERI A	6. 01	o	1, 261, 931	2.00
	TOTALS			1, 357, 201	
	C - ADMIN DIRECTOR		'	<u> </u>	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	29, 683	0	1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	18, 653	0	2. 00
3.00	ADULTS & PEDIATRICS	30.00	178, 118	0	3. 00
4.00	OPERATING ROOM	50.00	106, 682	0	4. 00
5.00	CARDI AC CATHETERI ZATI ON	59. 00	46, 641	0	5. 00
6.00	RESPI RATORY THERAPY	65. 00	86, 589	0	6. 00
7.00	ELECTROCARDI OLOGY	69. 00	59, 098	0	7. 00
8.00	CARDI AC REHAB	69. 01	15, 547	0	8. 00
9.00	CLINIC	90.00	28, 863	0	9.00
10.00	AMBULANCE SERVICES	95.00	33, 786	0	10.00
11. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	19, 838	U	11. 00
12. 00	GREAT BEGINNINGS/MATERNAL	192. 03	4, 687	0	12. 00
13. 00	PARI SH NURSI NG	192.08	9, 617	0	13. 00
14. 00	BI OTERRORI SM GRANT	192.09	19, 480	Ö	14. 00
15. 00	BREAST PUMPS	192. 10	1, 172		15. 00
	TOTALS		658, 454	0	10.00
	D - ADVERTISING	1	2227 12 1	-,	
1.00	ADVERTI SI NG	194. 03	189, 993	115, 484	1. 00
	TOTALS		189, 993	115, 484	
	E - LEASED PROPERTY				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	27, 463	1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	112, 918	2. 00
3.00	OPERATION OF PLANT	7. 00	0	381, 689	3. 00
4.00	HOUSEKEEPI NG	9. 00	0	8, 699	4. 00
5.00	DI ETARY	10. 00	0	27, 414	5. 00
6.00	OPERATING ROOM	50. 00	0	177, 209	6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	289, 141	7. 00
8.00	CT SCAN	57.00	0	20, 036	8. 00
9. 00	MAGNETIC RESONANCE I MAGING	58. 00	O	22, 551	9. 00
10. 00	(MRI) LABORATORY	60.00	o	64, 037	10.00
11. 00	ELECTROCARDI OLOGY	69.00	0	16, 264	11.00
12. 00	CARDI AC REHAB	69. 01	0	14, 705	12.00
13. 00	CLINIC	90.00	0	32, 098	13. 00
14. 00	PARI SH NURSI NG	192. 08	o	3, 876	14. 00
15. 00	MGH PHYS PRACT MGMT	192. 14	0	44, 652	15. 00
16. 00	MGH MARION SURGEONS	192. 15	0	30, 081	16. 00
17.00	MGH FMC SOUTH	192. 17	0	328, 665	17. 00
18.00	MGH FMC MARION	192. 19	0	78, 141	18. 00
19.00	MGH WORK SOLUTIONS	194. 04	0	11, 074	19. 00
20.00	MGH FMC NORTHWOOD	193. 01	O	1, 239	20. 00
21.00	MGH FMC GAS CITY	193. 02	0	2, 133	21. 00
22. 00	MGH FMC SWAYZEE	193. 05	0	24, 989	22. 00
23. 00	MGH PEDIATRIC CTR	193. 06	0	39, 960	23. 00
24. 00	MGH SPECIALTY PHYS	193. 07	0	38, 722	24. 00
25. 00	MGH UPLAND HEALTH	193. 09	0	6, 345	25. 00
26. 00	MGH MGH PSYCHIATRY	193. 11	0	13, 977	26. 00
27. 00	OB/GYN	1 <u>93.</u> 12	0	<u>12, 7</u> 83	27. 00
	TOTALS		0	1, 830, 861	
1. 00	F - PHARMACY RECLASS DRUGS CHARGED TO PATIENTS	73.00	٥	6, 372, 733	1.00
1.00	TOTALS		0	6, 372, 733	1.00
	G - CT/MRI RECLASS		<u> </u>	0, 372, 733	
1.00	CT SCAN	57.00	430, 497	369, 952	1.00
2.00	MAGNETIC RESONANCE I MAGING	58.00	246, 188	211, 564	2. 00
00	(MRI)	30. 33	2.5, 100	, 55	2.00
	TOTALS	+	676, 685	581, 516	
	H - SHORT TERM DISABILITY		,		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	518	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	49, 706	2. 00
3.00	PHARMACY	15. 00	o	5, 528	3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	40, 018	4. 00
5.00	INTENSIVE CARE UNIT	31. 00	0	10, 455	5. 00
6. 00	SUBPROVI DER - I RF	41. 00	0	1, 732	 6. 00
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Health Financial Systems RECLASSIFICATIONS MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 150011

					11/20/2014 2:46 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4.00	5.00	
7.00	OPERATING ROOM	50.00	0	17, 687	7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	15, 690	8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1, 494	9.00
10.00	LABORATORY	60.00	0	4, 019	10.00
11. 00	ONCOLOGY	60. 01	0	8, 593	11.00
12.00	RESPI RATORY THERAPY	65.00	0	7, 488	12.00
13.00	PHYSI CAL THERAPY	66.00	0	1, 628	13.00
14.00	ELECTROCARDI OLOGY	69.00	0	716	14.00
15.00	CLINIC	90.00	0	1, 250	15. 00
16.00	EMERGENCY	91.00	0	16, 939	16. 00
17.00	AMBULANCE SERVICES	95.00	0	12, 775	17. 00
18.00	MGH PHYS PRACT MGMT	192. 14	0	1, 719	18.00
19.00	MGH FMC SOUTH	192. 17	0	388	19.00
20.00	MGH FMC MARION	192. 19	0	2, 264	20.00
21. 00	MGH MAR FAM PRACT	193. 04	0	1, 169	21.00
22.00	MGH FMC SWAYZEE	193. 05	0	125	22. 00
23.00	MGH PEDIATRIC CTR	193. 06	0	1, 611	23.00
24.00	MGH MGH PSYCHLATRY	193. 11	0	42	24. 00
25.00	GREAT BEGINNINGS/MATERNAL	192.03	0	188	25. 00
26.00	MGH WORK SOLUTIONS	194.04	0	1, 392	26. 00
27.00	MGH FAIRM MED ASSOC	192. 18	0	1, 331	27. 00
28. 00	MGH FMC NORTHWOOD	193. 01	0	658	28. 00
29. 00	OB/GYN	193. 12	0	589	29. 00
30.00	MGH SPECIALTY PHYS	193. 07	0	2, 190	30.00
31.00	MGH UPLAND HEALTH	193.09	0	<u>3, 1</u> 35	31.00
	TOTALS		0	213, 037	
	I - NURSERY RECLASS				
1.00	NURSERY	4300	91 <u>6, 1</u> 52	15 <u>0, 9</u> 38	1.00
	TOTALS		916, 152	150, 938	
500.00	Grand Total: Increases		2, 575, 511	10, 645, 961	500.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 07/01/2013 To 06/30/2014 Date/Time Prepared: Provider CCN: 150011

					ļ.	4 2:46 pm
		Decreases				
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.	
	6.00 A - SATELITE OFFICE	7. 00	8. 00	9. 00	10. 00	
1.00	LABORATORY	60.00	4, 974	2, 123	0	1.00
2.00	LABORATORY	60.00	129, 253	22, 068	1	2. 00
	TOTALS		134, 227	24, 191		
4 00	B - CAFETERIA	10.00		4 0/4 004		1 00
1. 00 2. 00	DI ETARY DI ETARY	10. 00 10. 00	0	1, 261, 931 95, 270		1. 00 2. 00
2.00	TOTALS			9 <u>5, 270</u> 1, 357, 201		2.00
	C - ADMIN DIRECTOR		<u></u> Ч_	1, 337, 201		
1.00	ADMINISTRATIVE & GENERAL	5. 00	24, 674	0		1. 00
2.00	OPERATION OF PLANT	7. 00	19, 480	0		2. 00
3. 00	NURSI NG ADMI NI STRATI ON	13. 00	541, 178	0		3. 00
4.00	INTENSIVE CARE UNIT	31.00	29, 683	0		4. 00
5. 00 6. 00	EMERGENCY	91. 00 0. 00	43, 439 0	0		5. 00 6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	o	0		8. 00
9.00		0.00	O	0		9. 00
10.00		0.00	О	0		10. 00
11. 00		0. 00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	0	0		15. 00
13.00	TOTALS — — — —		658, 454	- - - - - - - - -	— — -	13.00
	D - ADVERTISING		000/ 10 1			
1.00	ADMI NI STRATI VE & GENERAL	5.00	189, 993	11 <u>5, 4</u> 84		1. 00
	TOTALS		189, 993	115, 484		
1. 00	E - LEASED PROPERTY NEW CAP REL COSTS-BLDG &	1.00	O	1, 396, 792	9	1.00
1.00	FIXT	1.00	٩	1, 370, 772	7	1.00
2.00	OWNED PROPERTIES	192. 05	O	434, 069	0	2. 00
3.00		0.00	О	0		3. 00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00	1	0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	o	0		8. 00
9. 00		0.00	o	0		9. 00
10.00		0.00	O	0		10. 00
11. 00		0. 00	O	0	0	11. 00
12.00		0. 00	0	0		12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	o	0		17. 00
18.00		0.00	O	0	0	18. 00
19. 00		0.00	0	0		19. 00
20. 00		0. 00	0	0		20. 00
21. 00		0.00	0	0		21.00
22. 00 23. 00	1	0. 00 0. 00	0	0	0	22. 00 23. 00
24. 00		0.00	Ö	0		24. 00
25. 00		0.00	Ö	0		25. 00
26.00		0.00	O	0	0	26. 00
27. 00		0.00		0	0	27. 00
	TOTALS F - PHARMACY RECLASS		0	1, 830, 861		
1. 00	PHARMACY RECLASS	15. 00	0	6, 372, 733	0	1. 00
1.00	TOTALS — — —		- — — 	6, 372, 733		1.00
	G - CT/MRI RECLASS				<u>'</u>	
1.00	RADI OLOGY-DI AGNOSTI C	54.00	676, 685	581, 516		1. 00
2.00				0		2. 00
	TOTALS H - SHORT TERM DISABILITY		676, 685	581, 516		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	518	0	O	1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	49, 706	0		2. 00
3. 00	PHARMACY	15. 00	5, 528	0		3. 00
4.00	ADULTS & PEDIATRICS	30. 00	40, 018	0	0	4. 00
5.00	INTENSIVE CARE UNIT	31.00	10, 455	0		5. 00
6.00	SUBPROVI DER - I RF	41.00	1, 732	0		6. 00
7.00	OPERATING ROOM	50.00	17, 687	0		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54. 00	15, 690	0	0	8. 00

Peri od: From 07/01/2013 To 06/30/2014 Date/Time Prepared: 11/20/2014 2: 46 pm

		Decreases		<u> </u>		, 23, 23 2.	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
9.00	CARDIAC CATHETERIZATION	59. 00	1, 494	0	0		9. 00
10.00	LABORATORY	60.00	4, 019	0	0		10. 00
11.00	ONCOLOGY	60. 01	8, 593	0	0		11. 00
12.00	RESPIRATORY THERAPY	65. 00	7, 488	0	0		12. 00
13.00	PHYSI CAL THERAPY	66. 00	1, 628	0	0		13. 00
14.00	ELECTROCARDI OLOGY	69. 00	716	0	0		14. 00
15.00	CLINIC	90.00	1, 250	0	0		15. 00
16.00	EMERGENCY	91.00	16, 939	0	0		16. 00
17.00	AMBULANCE SERVICES	95. 00	12, 775	0	0		17. 00
18.00	MGH PHYS PRACT MGMT	192. 14	1, 719	0	0		18. 00
19.00	MGH FMC SOUTH	192. 17	388	0	0		19. 00
20.00	MGH FMC MARION	192. 19	2, 264	0	0		20. 00
21.00	MGH MAR FAM PRACT	193. 04	1, 169	0	0		21. 00
22.00	MGH FMC SWAYZEE	193. 05	125	0	0		22. 00
23.00	MGH PEDIATRIC CTR	193. 06	1, 611	0	0		23. 00
24.00	MGH MGH PSYCHLATRY	193. 11	42	0	0		24. 00
25.00	GREAT BEGINNINGS/MATERNAL	192. 03	188	0	0		25. 00
26.00	MGH WORK SOLUTIONS	194. 04	1, 392	0	0		26. 00
27.00	MGH FAIRM MED ASSOC	192. 18	1, 331	0	0		27. 00
28.00	MGH FMC NORTHWOOD	193. 01	658	0	0		28. 00
29. 00	OB/GYN	193. 12	589	0	0		29. 00
30.00	MGH SPECIALTY PHYS	193. 07	2, 190	0	0		30. 00
31.00	MGH UPLAND HEALTH	193. 09	3, 135	0	0		31.00
	TOTALS		213, 037	0			
	I - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	916, 152	15 <u>0, 9</u> 38	0		1. 00
	TOTALS		916, 152	150, 938			1
500.00	Grand Total: Decreases		2, 788, 548	10, 432, 924			500.00

					0 06/30/2014	11/20/2014 2:	
	Cost Center	ases Li ne #	Salary	Cost Center	Li ne #	Sal ary	
	2.00	3.00	4. 00	6.00	7. 00	8. 00	
	A - SATELITE OFFICE						
1.00	ELECTROCARDI OLOGY	69. 00		LABORATORY	60. 00	4, 974	1. 00
2. 00	RADI OLOGY - DI AGNOSTI C	<u>54.</u> 00		LABORATORY	6000	12 <u>9, 2</u> 53	2. 00
	TOTALS B - CAFETERIA		134, 227	IUIALS		134, 227	
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	DI ETARY	10.00	0	1. 00
2.00	CAFETERI A	6. 01		DI ETARY	10. 00	0	2. 00
	TOTALS		0	TOTALS		0	
4 00	C - ADMIN DIRECTOR	4 00	00 (00	ADMINISTRATIVE & SEMEDAL	F 00	04 (74	4 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT CENTRAL SERVICES & SUPPLY	4. 00 14. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	24, 674 19, 480	1. 00 2. 00
3. 00	ADULTS & PEDIATRICS	30.00		NURSING ADMINISTRATION	13. 00	541, 178	3. 00
4. 00	OPERATING ROOM	50.00		INTENSIVE CARE UNIT	31. 00	29, 683	4. 00
5.00	CARDIAC CATHETERIZATION	59.00		EMERGENCY	91. 00	43, 439	5. 00
6.00	RESPI RATORY THERAPY	65. 00	86, 589		0. 00	0	6. 00
7. 00	ELECTROCARDI OLOGY	69. 00	59, 098		0. 00	0	7. 00
8.00	CARDI AC REHAB	69. 01	15, 547		0.00	0	8. 00
9. 00 10. 00	CLINIC AMBULANCE SERVICES	90. 00 95. 00	28, 863 33, 786		0. 00 0. 00	0	9. 00 10. 00
11. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	19, 838		0.00	0	11. 00
	CANTEEN		,]	
12.00	GREAT BEGINNINGS/MATERNAL	192. 03	4, 687		0. 00	O	12. 00
13. 00	PARI SH NURSI NG	192. 08	9, 617		0. 00	0	13. 00
14. 00	BI OTERRORI SM GRANT	192. 09	19, 480		0.00	0	14.00
15. 00	BREAST PUMPS	1 <u>92.</u> 10	<u>1, 1</u> 72 658, 454		000	658, 454	15. 00
	D - ADVERTISING		030, 434	TOTALS		030, 434	
1.00	ADVERTI SI NG	194. 03		ADMINISTRATIVE & GENERAL	5. 00	189, 993	1. 00
	TOTALS		189, 993	TOTALS		189, 993	
1 00	E - LEASED PROPERTY	4 00	0	NEW CAR DEL COSTS DIDC 0	1 00	0	1 00
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	U	NEW CAP REL COSTS-BLDG &	1. 00	U	1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	OWNED PROPERTIES	192. 05	o	2. 00
3.00	OPERATION OF PLANT	7. 00	0		0. 00	О	3. 00
4.00	HOUSEKEEPI NG	9. 00	0	1	0. 00	0	4. 00
5.00	DIETARY	10.00	0		0.00	0	5. 00
6. 00 7. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	1	0. 00 0. 00	0	6. 00 7. 00
8. 00	ICT SCAN	57.00	0		0.00	0	8. 00
9. 00	MAGNETIC RESONANCE I MAGING	58.00	0	1	0.00	ő	9. 00
	(MRI)						
10.00	LABORATORY	60.00	0	1	0. 00	0	10.00
11. 00	ELECTROCARDI OLOGY	69.00	0	1	0.00	0	11. 00
12. 00 13. 00	CARDI AC REHAB	69. 01 90. 00	0	1	0. 00 0. 00	0	12. 00 13. 00
14. 00	PARI SH NURSI NG	192. 08	0		0.00	0	14. 00
15. 00	MGH PHYS PRACT MGMT	192. 14	0		0. 00	O	15. 00
16.00	MGH MARION SURGEONS	192. 15	0		0. 00	O	16.00
17. 00	MGH FMC SOUTH	192. 17	0		0. 00	0	
18.00	MGH FMC MARION	192. 19	0		0.00	0	18.00
19. 00 20. 00	MGH WORK SOLUTIONS MGH FMC NORTHWOOD	194. 04 193. 01	0	•	0. 00 0. 00	0	19. 00 20. 00
21. 00	MGH FMC GAS CITY	193. 01	0		0.00	0	21. 00
22. 00	MGH FMC SWAYZEE	193. 05	0		0. 00	Ö	22. 00
23. 00	MGH PEDIATRIC CTR	193. 06	0		0. 00	O	23. 00
24. 00	MGH SPECIALTY PHYS	193. 07	0		0. 00	0	24. 00
25. 00	MGH UPLAND HEALTH	193. 09	0	1	0.00	0	25. 00
26. 00 27. 00	MGH MGH PSYCHIATRY OB/GYN	193. 11 193. 12	0		0. 00 0. 00	0	26. 00 27. 00
27.00	TOTALS — — —		— — —	TOTALS — — — —		— — — ŏ	27.00
	F - PHARMACY RECLASS	<u> </u>					
1.00	DRUGS CHARGED TO PATIENTS		:	PHARMACY	1500	0	1. 00
	TOTALS		0	TOTALS		0	
1. 00	G - CT/MRI RECLASS CT SCAN	57.00	430 407	RADI OLOGY-DI AGNOSTI C	54. 00	676, 685	1. 00
2. 00	MAGNETIC RESONANCE I MAGING	58.00	246, 188		0.00	070,003	2. 00
	(MRI)]	
	TOTALS		676, 685	TOTALS		676, 685	
1 00	H - SHORT TERM DISABILITY	4.00		EMDLOVEE DENEELTS DEDADTMENT	4 00	E10	1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	518 49, 706	1. 00 2. 00
3.00	PHARMACY	15. 00		PHARMACY	15. 00	5, 528	3. 00
4.00	ADULTS & PEDIATRICS	30.00		ADULTS & PEDIATRICS	30. 00	40, 018	
5.00	INTENSIVE CARE UNIT	31.00		INTENSIVE CARE UNIT	31. 00	10, 455	5. 00
-	<u>`</u>	-		·		<u>.</u>	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150011

						11/20/2014 2:	46 pm
	Incre	eases		Decr	eases		
	Cost Center	Li ne #	Sal ary	Cost Center	Li ne #	Sal ary	
	2. 00	3.00	4.00	6. 00	7. 00	8. 00	
6.00	SUBPROVI DER - I RF	41. 00		O SUBPROVI DER - I RF	41. 00	1, 732	6. 00
7.00	OPERATING ROOM	50.00		O OPERATING ROOM	50.00	17, 687	7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00		O RADI OLOGY-DI AGNOSTI C	54. 00	15, 690	8. 00
9.00	CARDIAC CATHETERIZATION	59. 00		O CARDIAC CATHETERIZATION	59. 00	1, 494	9. 00
10.00	LABORATORY	60.00		O LABORATORY	60.00	4, 019	10.00
11. 00	ONCOLOGY	60. 01		OONCOLOGY	60. 01	8, 593	11.00
12.00	RESPI RATORY THERAPY	65. 00		O RESPIRATORY THERAPY	65. 00	7, 488	12.00
13.00	PHYSI CAL THERAPY	66.00		O PHYSI CAL THERAPY	66. 00	1, 628	13.00
14.00	ELECTROCARDI OLOGY	69. 00		O ELECTROCARDI OLOGY	69. 00	716	14.00
15.00	CLINIC	90.00		OCLINIC	90.00	1, 250	15. 00
16.00	EMERGENCY	91. 00		OEMERGENCY	91. 00	16, 939	16.00
17.00	AMBULANCE SERVICES	95. 00		O AMBULANCE SERVICES	95. 00	12, 775	17.00
18.00	MGH PHYS PRACT MGMT	192. 14		OMGH PHYS PRACT MGMT	192. 14	1, 719	18. 00
19.00	MGH FMC SOUTH	192. 17		OMGH FMC SOUTH	192. 17	388	19. 00
20.00	MGH FMC MARION	192. 19		OMGH FMC MARION	192. 19	2, 264	20.00
21.00	MGH MAR FAM PRACT	193. 04		OMGH MAR FAM PRACT	193. 04	1, 169	21.00
22.00	MGH FMC SWAYZEE	193. 05		OMGH FMC SWAYZEE	193. 05	125	22. 00
23.00	MGH PEDIATRIC CTR	193. 06		OMGH PEDIATRIC CTR	193. 06	1, 611	23.00
24.00	MGH MGH PSYCHLATRY	193. 11		OMGH MGH PSYCHLATRY	193. 11	42	24.00
25.00	GREAT BEGINNINGS/MATERNAL	192. 03		OGREAT BEGINNINGS/MATERNAL	192. 03	188	25.00
26.00	MGH WORK SOLUTIONS	194. 04		OMGH WORK SOLUTIONS	194. 04	1, 392	26.00
27.00	MGH FAIRM MED ASSOC	192. 18		OMGH FAIRM MED ASSOC	192. 18	1, 331	27. 00
28.00	MGH FMC NORTHWOOD	193. 01		OMGH FMC NORTHWOOD	193. 01	658	28. 00
29.00	OB/GYN	193. 12		O OB/GYN	193. 12	589	29. 00
30.00	MGH SPECIALTY PHYS	193. 07		OMGH SPECIALTY PHYS	193. 07	2, 190	30.00
31.00	MGH UPLAND HEALTH	193. 09		OMGH UPLAND HEALTH	193. 09	3, 135	31.00
	TOTALS			O TOTALS		213, 037	
	I - NURSERY RECLASS						
1.00	NURSERY	43.00		2 ADULTS & PEDI ATRI CS	30.00	916, 152	1.00
	TOTALS			2 TOTALS		916, 152	
500.00	Grand Total: Increases		2, 575, 51	1 Grand Total: Decreases		2, 788, 548	500.00

				T	o 06/30/2014	Date/Time Prep	
				Acqui oi ti ono		11/20/2014 2:	46 pm
		Doginaina	Purchases	Acqui si ti ons Donati on	Total	Di anggal a gnd	
		Begi nni ng Bal ances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3.00	4.00	3.00	
1.00	Land	4, 422, 248	0	0	0	0	1. 00
2.00	Land Improvements	3, 261, 359	1, 300	0	1, 300	0	2. 00
3.00	Buildings and Fixtures	106, 649, 620	1, 727, 562	0	1, 727, 562	59, 813	3. 00
4. 00	Building Improvements	859, 249	0	0	0	0	4. 00
5. 00	Fixed Equipment	1, 241, 378	0	0	0	0	5. 00
6.00	Movable Equipment	74, 671, 192	4, 108, 820	0	4, 108, 820	4, 001, 935	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	191, 105, 046	5, 837, 682	0	5, 837, 682	4, 061, 748	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	191, 105, 046	5, 837, 682	0	5, 837, 682	4, 061, 748	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	4, 422, 248	0				1. 00
2.00	Land Improvements	3, 262, 659	0				2. 00
3.00	Buildings and Fixtures	108, 317, 369	0				3. 00
4.00	Building Improvements	859, 249	0				4. 00
5.00	Fi xed Equi pment	1, 241, 378	0				5. 00
6.00	Movable Equipment	74, 778, 077	0				6. 00
7.00	HIT designated Assets	100 000 000	0				7. 00
8.00	Subtotal (sum of lines 1-7)	192, 880, 980	0				8. 00
9. 00 10. 00	Reconciling Items	102 000 000	0				9.00
10.00	Total (line 8 minus line 9)	192, 880, 980	0				10. 00

Heal th	Financial Systems	MARION GENERA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150011	Peri od:	Worksheet A-7	
					From 07/01/2013 To 06/30/2014		narad:
					10 00/30/2014	11/20/2014 2:	
			SU	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	12, 800, 113	0		0	0	1. 00
3.00	Total (sum of lines 1-2)	12, 800, 113	0		0 0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00	L			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI	<u> </u>				
1. 00	NEW CAP REL COSTS-BLDG & FIXT	0	12, 800, 113				1. 00
3. 00	Total (sum of lines 1-2)	0	12, 800, 113				3. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
				From 07/01/2013 To 06/30/2014		arod.
				10 00/30/2014	11/20/2014 2: 4	
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	. C D
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col			
			2)			
DART ALL DESCRIPTION OF CARLEY COOKS OF	1.00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			104 077 70	4 00000		4 00
1.00 NEW CAP REL COSTS-BLDG & FLXT	191, 976, 738		191, 976, 73			1. 00
3.00 Total (sum of lines 1-2)	191, 976, 738		191, 976, 73			3. 00
	ALLUCA	TION OF OTHER (JAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
cost center bescription		Capi tal -Relate		Depi eci ati on	Lease	
		d Costs	through 7)			
	6. 00	7.00	8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		7100	0.00	7, 00	10100	
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 11, 404, 110	0	1. 00
3.00 Total (sum of lines 1-2)	0	0		0 11, 404, 110		3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DADT III DECONOLILIATION OF CARLTY COOTS OF	11.00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			1		44 007 000	
1.00 NEW CAP REL COSTS-BLDG & FIXT	-197, 181			0	, = , . = -	1. 00
3.00 Total (sum of lines 1-2)	-197, 181	0	1	0 0	11, 206, 929	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 150011

			To 06/30/2014				oared: 46 pm
				Expense Classification on To/From Which the Amount is		, 20, 20 2.	, o p
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5. 00 0	1. 00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-492, 923		0. 00	0	9. 00 10. 00
	adj ustment	A-0-2	-472, 723		0.00		
11. 00	Sale of scrap, waste, etc. (chapter 23)		O		0.00	0	
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-23, 813	CAFETERI A	0. 00 6. 01	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0)	0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		U		0.00	U	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL			*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
20.00	pathology costs in excess of limitation (chapter 14)		-		2.63		20.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	
33. 00	RETURNED CHECK FEE	В	-1, 040	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provi der CCN: 150011 Peri od: Worksheet A-8 From 07/01/2013 Date/Time Prepared:

				Ť	06/30/2014	Date/Time Pre 11/20/2014 2:	
				Expense Classification on		1172072011 2.	lo piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost center bescriptron	1.00	2.00	3.00	4. 00	5. 00	
33. 01	PHONE SERVI CE FEE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 02	PHYSICIAN PRIV APPLICATION	B B		ADMINISTRATIVE & GENERAL	5.00	l	
33. 03	SALE OF MEDICAL RECORDS & ABSTRACTS	В	-63, 548	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	CHILD SEAT SAFETY INSPECTION	В	-230	ADMINISTRATIVE & GENERAL	5. 00	О	33. 04
33. 05	HEALTH SCREENING FEES-LAB	В		LABORATORY	60.00	l .	33. 05
33. 06	HEALTH SCREENING FEES-RAD	В		RADI OLOGY-DI AGNOSTI C	54.00	l e	
33. 07	MED STAFF OTHER SCREENING-MED STAFF	В	1, 046	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	FLU SHOT HEALTH SCREENS	В	-400	ADMINISTRATIVE & GENERAL	5. 00	О	33. 08
33. 09	EMERGENCY DRUG SALES	В	-2, 326	PHARMACY	15. 00	0	33. 09
33. 10	REBATE	В		ADMI NI STRATI VE & GENERAL	5. 00	l	
33. 11	RENTAL OF PROVIDER SPACE BY SUPPLIER	В	-1, 200	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	RENT SPACE OTHER CONFERENCE	В	-500	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
22 12	ROOM	D	2 070	ADMINISTRATIVE & CENERAL	F 00	_	22 12
33. 13 33. 14	PAGER RENTAL SALE OF SCRAP, WASTE, ETC	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 13 33. 14
33. 15	SALES OF XRAY FILM	В	·	RADI OLOGY-DI AGNOSTI C	54.00	ő	
33. 16	EMPL UNI FORMS	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 17	PCC MARKETING AG	В		ADMI NI STRATI VE & GENERAL	5. 00	1	
33. 18 33. 19	EDUCATIONAL WORKSHOP OPT HEALTH LINEN SEV	B B		ADMINISTRATIVE & GENERAL LAUNDRY & LINEN SERVICE	5. 00 8. 00	0	
33. 20	AMBULANCE SVC-ASSISTS	В		AMBULANCE SERVICES	95.00		1
33. 21	AMBULANCE SVC-CORONER SVC	В		AMBULANCE SERVICES	95.00	0	1
33. 22	AMBULANCE SVC-LINEN SERVICE	В		LAUNDRY & LINEN SERVICE	8. 00	i e	
33. 23	AMBULANCE SVC-COMMUNITY EVENT	В	-1, 848	AMBULANCE SERVICES	95.00	0	33. 23
33. 24	CONTRACT ARU OTHR ARU MED DIR	В	-62, 750	SUBPROVI DER - I RF	41.00	0	33. 24
33. 25	SCHOOL PHYS OTH SCHOOL PHY	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	PRECEPT OTHER PHARMACY STUDENT	1		DRUGS CHARGED TO PATIENTS	73. 00	l	
33. 27	PRACT STUD OTHER IT PRACTICUM STUDEN	В	-2, 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
33. 28	SICK CHILD CARE PROGRAM	В	-943	ADULTS & PEDIATRICS	30.00	О	33. 28
33. 29	UNCLAIMED OTHER STATE MONIES	В	-292	ADMINISTRATIVE & GENERAL	5. 00	0	33. 29
33. 30	RECOVER UNCLAIMED OTHER 125 MED/CHILD	В	- 27 086	ADMINISTRATIVE & GENERAL	5. 00	0	33. 30
33. 30	CARE		27,000	NOW IN STRAIT VE & GENERAL	3.00		33. 30
33. 31	VENDING MACHINES	В		CAFETERI A	6. 01	0	
33. 32	CPR TRAIN OTHER AHA COMMUNITY	В	•	ADMINISTRATIVE & GENERAL	5. 00	1	
33. 33 33. 34	PHYSICIAN RECRUITMENT ED ANESTHESIOLOGIST	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	
33. 35	GAIN ON DISPOSAL	A		ADMINISTRATIVE & GENERAL	5. 00	l	
33. 36	TELEVISION AND RADIO SERVICE	A		OPERATION OF PLANT	7. 00	0	
33. 37	TELEPHONE SERVICE	A		ADMINISTRATIVE & GENERAL	5.00	l e	
33. 38 33. 39	TELEPHONE SERVI CE MI SC REVENUE	A B		OPERATION OF PLANT ADMINISTRATIVE & GENERAL	7. 00 5. 00	l e	
33. 40	ENTERTAL NMENT EXP	A		ADMINISTRATIVE & GENERAL	5. 00		1
33. 41	EMPLOYEE USE OF AUTO	A		ADMINISTRATIVE & GENERAL	5. 00	1	
33. 42	DONATI ONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 43 33. 44	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	
33. 45	VHA OPPORTUNI TY	A		OPERATION OF PLANT	7. 00	0	
33. 46	VHA OPPORTUNI TY	A		LAUNDRY & LINEN SERVICE	8. 00	Ö	1
33. 47	VHA OPPORTUNI TY	A		HOUSEKEEPI NG	9. 00	0	
33. 48	VHA OPPORTUNI TY	A	·	DI ETARY	10.00	0	
33. 49 33. 50	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	
33. 51	VHA OPPORTUNI TY	Ä		ADULTS & PEDIATRICS	30.00	ő	
33. 52	VHA OPPORTUNI TY	A	-588	INTENSIVE CARE UNIT	31.00	0	33. 52
33. 53	VHA OPPORTUNITY	A		SUBPROVI DER - I RF	41.00	0	
33. 54 33. 55	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	
33. 56	VHA OPPORTUNI TY	A		LABORATORY	60.00	0	
33. 57	VHA OPPORTUNI TY	A		ONCOLOGY	60. 01	Ō	
33. 58	VHA OPPORTUNITY	A		RESPI RATORY THERAPY	65.00	0	
33. 59 33. 60	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		PHYSICAL THERAPY CARDIAC REHAB	66. 00 69. 01	0	
33. 60	l control of the cont	A		CARDI AC REHAB CARDI AC CATHETERI ZATI ON	59.00	l	1
						•	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150011 Peri od: Worksheet A-8 From 07/01/2013 | WOLKSHEEL A-0
From 07/01/2013 |
To 06/30/2014 | Date/Time Prepared:

				To	06/30/2014	Date/Time Prep 11/20/2014 2:4	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adiusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4. 00	5. 00	
33. 62	VHA OPPORTUNITY	A A		ELECTROCARDI OLOGY	69.00	0.00	33. 62
33. 63	VHA OPPORUTNI TY	A		CLINIC	90.00	0	33. 63
33. 64	VHA OPPORTUNI TY	A		EMERGENCY	91.00	0	33. 64
		1	·	1		-	
33. 65	VHA OPPORTUNITY	A		AMBULANCE SERVICES	95.00	0	33. 65
33. 66	FINANCE BANK SERVICE CHARGES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 66
33. 67	FINANCE DISCOUNT PAYMENTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 67
33. 68	NONALLOWABLE 2008 BONDS	A	-168, 517	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 68
				FLXT			
33. 69	BLDG COSTS	A	789	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 69
				FLXT			
33. 70	ELIMINATING ENTRIES	A	-61, 392	MGH PHYS PRACT MGMT	192. 14	0	33. 70
33. 71	ELIMINATING ENTRIES	A	-101, 516	MGH WORK SOLUTIONS	194.04	0	33. 71
33. 72	ELIMINATING ENTRIES	A	-114, 317	MGH FMC MARION	192. 19	0	33. 72
33. 73	ELIMINATING ENTRIES	A	-28, 175	MGH FMC SWAYZEE	193. 05	0	33. 73
33.74	ELIMINATING ENTRIES	A	-61, 648	MGH PEDIATRIC CTR	193. 06	0	33. 74
33. 75	ELIMINATING ENTRIES	A	-18, 872	MGH MGH PSYCHLATRY	193. 11	0	33. 75
33. 76	ELIMINATING ENTRIES	A		MGH SPECIALTY PHYS	193. 07	0	33. 76
33. 77	ELIMINATING ENTRIES	A		MGH FMC SOUTH	192. 17	0	33. 77
33. 78	LOBBYING COSTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 78
33. 79	LOBBYING COSTS	A		NURSING ADMINISTRATION	13. 00	o	33. 79
33. 80	LOBBYING COSTS	A		PHARMACY	15. 00	0	33. 80
33. 81	LOBBYING COSTS	A		ONCOLOGY	60. 01	0	33. 81
33. 82	OPERATING INTEREST INCOME	B		NEW CAP REL COSTS-BLDG &	1.00	11	
33. 62	OPERATING INTEREST INCOME	D	-20,004	FIXT	1.00	'''	33. 02
22 02	ED ON CALL SVC	A	1 507 105		F 00	0	33. 83
33. 83	II .	1		ADMINISTRATIVE & GENERAL	5. 00	Ĭ	
33. 84	XIX ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 84
33. 85	SELF INSURANCE	A	-1, 345, 947	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 85
33. 86	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 86
	(3)						
33. 87	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 87
	(3)						
33. 88	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 88
	(3)						
33. 89	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 89
	(3)						
33. 90	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 90
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-15, 817, 476				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

 B. Amount Received if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						To 06/30/2014	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	10 p
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	41. 00	SUBPROVIDER - IRF	22, 150	22, 150	0	0	0	1. 00
2.00	69. 00	ELECTROCARDI OLOGY	53, 655	53, 655	0	0	0	2. 00
3.00	65. 00	RESPI RATORY THERAPY	9, 278	9, 278	0	0	0	3.00
4.00	91.00	EMERGENCY	165, 000	165, 000	0	0	0	4. 00
5.00	60.00	LABORATORY	6, 800	6, 800	0	0	0	5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	236, 040	236, 040	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			492, 923		0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		SUBPROVIDER - IRF	0	0	-	-	0	1. 00
2.00	•	ELECTROCARDI OLOGY	0	0		_	0	2. 00
3.00		RESPI RATORY THERAPY	0	0		-	0	3. 00
4.00		EMERGENCY	0	0		,	0	4. 00
5.00		LABORATORY	0	0	0	0	0	5. 00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	-	0	9. 00
10. 00	0. 00		0	0	0	,	0	10. 00
200.00		0 1 0 1 (8)	0	0	0		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		SUBPROVI DER - I RF	13.00					1. 00
2. 00		ELECTROCARDI OLOGY	0	Ö				2. 00
3. 00		RESPI RATORY THERAPY	0	0				3. 00
4. 00		EMERGENCY	0	0	_			4. 00
5. 00		LABORATORY	0	0	-			5. 00
6. 00		RADI OLOGY-DI AGNOSTI C		١	0	236, 040		6. 00
7. 00	0.00			١	0	200,040		7. 00
8. 00	0.00			0	0	1 0		8. 00
9. 00	0.00			0	-	l n		9. 00
10. 00	0.00			١	0	1 0		10. 00
200.00	3.00		0	Ö	0	492, 923		200. 00
200.00	I .	ı				1,2,,20		_55.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	MARION GENERA	Provi der		eriod: com 07/01/2013 o 06/30/2014		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	то рііі
		0	1. 00	4. 00	4A	5. 00	
1 00	GENERAL SERVICE COST CENTERS	11 20/ 020	11 20/ 020				1 00
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	11, 206, 929 16, 639, 228		17, 034, 162			1. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 509, 075		2, 656, 588	20, 976, 617	20, 976, 617	5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	1
6. 01	00601 CAFETERI A	1, 230, 209	147, 154	0	1, 377, 363	251, 827	6. 01
6. 02	00602 CAFETERI A	0	0	0	0	0	
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	4, 168, 332 377, 419		165, 643	7, 231, 994 441, 666	1, 322, 247 80, 751	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	2, 418, 581	101, 568	0	2, 520, 149	460, 766	9. 00
	01000 DI ETARY	593, 974	206, 235	0	800, 209	146, 305	1
	01300 NURSING ADMINISTRATION	870, 868		301, 107	1, 193, 249	218, 165	13. 00
	01400 CENTRAL SERVICES & SUPPLY	734, 147	l	84, 211	890, 811	162, 870	
15. 00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 733, 985	92, 845	817, 703	3, 644, 533	666, 341	15. 00
30. 00	03000 ADULTS & PEDIATRICS	9, 073, 349	1, 337, 611	2, 892, 787	13, 303, 747	2, 432, 393	30.00
	03100 INTENSIVE CARE UNIT	2, 827, 118		895, 942	4, 027, 277	736, 319	
	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
	04100 SUBPROVI DER – I RF	1, 661, 124	290, 176	354, 639	2, 305, 939	421, 602	1
	04200 SUBPROVI DER 04300 NURSERY	1, 067, 090	0	0 327, 680	0 1, 394, 770	0 255, 010	42. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	1,007,090	<u> </u>	327, 080	1, 374, 770	255, 010	43.00
50.00	05000 OPERATI NG ROOM	7, 859, 932	1, 066, 095	1, 108, 364	10, 034, 391	1, 834, 618	50. 00
	05100 RECOVERY ROOM	0	-1	0	0	0	51.00
	05400 RADI OLOGY-DI AGNOSTI C	4, 225, 265		836, 202	5, 719, 255	1, 045, 669	
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	820, 485 480, 303		153, 976 88, 054	1, 020, 686 703, 416	186, 615 128, 608	
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 199, 281	153, 037	204, 430	3, 556, 883	650, 316	1
60. 00	06000 LABORATORY	6, 888, 072		902, 716	8, 145, 910	1, 489, 341	1
	06001 ONCOLOGY	1, 447, 950	o	339, 908	1, 787, 858	326, 879	60. 01
	06002 RADI ATI ON ONCOLOGY	0	0	0	0	0	
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 936, 356		454, 735	2, 530, 678	462, 691 455, 494	65. 00
66. 00 69. 00	06900 ELECTROCARDI OLOGY	1, 954, 126 766, 935		510, 411 255, 264	2, 491, 312 1, 267, 487	231, 738	
	06901 CARDI AC REHAB	133, 917	39, 417	40, 148	213, 482	39, 032	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	6, 371, 933	0	0	6, 371, 933	1, 165, 000	73. 00
90. 00	09000 CLINIC	318, 220	86, 068	70, 479	474, 767	86, 803	90.00
	09100 EMERGENCY	4, 442, 170	l	1, 307, 408	6, 086, 496	1, 112, 812	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	, ,	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS	040 440	407.045	204 742	4 050 07/	0.47, 000	05.00
95. 00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	919, 148	126, 215	304, 713	1, 350, 076	246, 838	95.00
113. 00	11300 I NTEREST EXPENSE						113. 00
118. 00		113, 875, 521	11, 155, 416	15, 073, 108	111, 862, 954	16, 617, 050	
	NONREI MBURSABLE COST CENTERS]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 674	40, 937	7, 095	81, 706	14, 939	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL	130, 077		46, 205	0 176, 282		192. 02 192. 03
	19204 LIFELINE	130,077		40, 205 0	170, 202 N		192. 03
	19205 OWNED PROPERTIES	559, 382		Ö	559, 382	102, 273	1
192. 08	19211 PARI SH NURSI NG	63, 661	10, 394	13, 885	87, 940	16, 078	192. 08
	19212 BI OTERRORI SM GRANT	44, 549	ı	6, 967	51, 516	0 /10	192. 09
	19214 BREAST PUMPS	2, 373		419	2, 974		192. 10

71. 00 0 7 100 EWENGENCT	4,442,170	330, 910	1, 307, 400	0, 000, 470	1, 112, 012 3
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	9
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0 9
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	919, 148	126, 215	304, 713	1, 350, 076	246, 838
SPECIAL PURPOSE COST CENTERS					
13. 00 11300 I NTEREST EXPENSE					11
18.00 SUBTOTALS (SUM OF LINES 1-117)	113, 875, 521	11, 155, 416	15, 073, 108	111, 862, 954	16, 617, 050 11
NONREI MBURSABLE COST CENTERS					
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 674	40, 937	7, 095	81, 706	14, 939 19
92.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 19
92. 02 19202 VISITOR MEALS	0	0	0	0	0 19
92. 03 19203 GREAT BEGINNINGS/MATERNAL	130, 077	0	46, 205	176, 282	32, 230 19
92. 04 19204 LI FELI NE	0	0	0	0	0 19
92. 05 19205 OWNED PROPERTIES	559, 382	0	0	559, 382	102, 273 19
92.08 19211 PARISH NURSING	63, 661	10, 394	13, 885	87, 940	16, 078 19
92.09 19212 BIOTERRORISM GRANT	44, 549	0	6, 967	51, 516	9, 419 19
92.10 19214 BREAST PUMPS	2, 373	182	419	2, 974	544 19
92.14 19210 MGH PHYS PRACT MGMT	1, 410, 393	0	373, 019	1, 783, 412	326, 067 19
92. 15 19215 MGH MARION SURGEONS	2, 041, 937	0	120, 312	2, 162, 249	395, 330 19
92. 16 19216 MGH MGH MED ONC	959, 621	0	0	959, 621	175, 450 19
92. 17 19217 MGH FMC SOUTH	2, 151, 892	0	216, 336	2, 368, 228	432, 990 19
92. 18 19218 MGH FAIRM MED ASSOC	511, 964	0	44, 847	556, 811	101, 803 19
92. 19 19219 MGH FMC MARION	792, 660	0	91, 001	883, 661	161, 562 19
93. 00 19300 NONPALD WORKERS	0	0	0	0	0 19
93. 01 19301 MGH FMC NORTHWOOD	752, 295	0	72, 185	824, 480	150, 742 19
93.02 19302 MGH FMC GAS CITY	798, 783	0	64, 094	862, 877	157, 762 19
93. 03 19303 MGH HOSPI TALI STS	2, 484, 201	0	11, 513	2, 495, 714	456, 299 19
93.04 19304 MGH MAR FAM PRACT	2, 080, 707	0	247, 074	2, 327, 781	425, 595 19

Peri od: Worksheet B
From 07/01/2013 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150011

			1	o 06/30/2014	Date/Time Prep 11/20/2014 2:4	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
	col . 7)					
	0	1.00	4. 00	4A	5. 00	
193. 05 19305 MGH FMC SWAYZEE	149, 979		17, 572			
193. 06 19306 MGH PEDIATRIC CTR	985, 947		73, 084			
193. 07 19307 MGH SPECIALTY PHYS	299, 613		28, 944	1		
193.08 19308 MGH FMC CONVERSE	227, 352		26, 304	1		
193.09 19309 MGH UPLAND HEALTH	1, 130, 886	0	128, 609	1, 259, 495		
193.10 19310 MGH MGH WOMENS CTR	0	0	(0		193. 10
193. 11 19311 MGH MGH PSYCHIATRY	498, 122		23, 134	521, 256		
193. 12 19312 OB/GYN	2, 207, 078	0	150, 539	2, 357, 617		
193.15 19315 MGH RIVER VIEW BLDG	0	0	(0		193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	(0		194. 00
194. 01 07950 MOW	0	0	(0		194. 01
194.02 07951 MENTAL HEALTH	0	0	(0		194. 02
194. 03 07952 ADVERTI SI NG	305, 477	0	67, 955	373, 432	68, 276	194. 03
194.04 07953 MGH WORK SOLUTIONS	728, 778	0	112, 281	841, 059	153, 773	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	150, 836	0	17, 680	168, 516		
194.08 07957 MGH SMMP BLDG	258, 587	0	(258, 587	47, 278	194. 08
194.09 07958 MGH AMBUCARE BLDG	59, 878		(59, 878	10, 948	194. 09
194.10 07959 MGH 106 LYONS BLDG	11, 272	0	(11, 272	2, 061	194. 10
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	(0		201. 00
202.00 TOTAL (sum lines 118-201)	135, 707, 495	11, 206, 929	17, 034, 162	135, 707, 495	20, 976, 617	202. 00

Provi der CCN: 150011

				1'	00/30/2014	11/20/2014 2:	
	Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
		REPAI RS 6.00	6. 01	6. 02	PLANT 7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.01	0.02	7.00	8.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	_					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	4 (00 400				6. 00
6. 01	00601 CAFETERI A	0	1, 629, 190	1 FOF 442			6. 01
6. 02 7. 00	O0602 CAFETERI A O0700 OPERATI ON OF PLANT	0	1, 505, 443	1, 505, 443 30, 745	8, 584, 986		6. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	30, 743	92, 608	615, 025	8. 00
9. 00	00900 HOUSEKEEPING	0	o	0	146, 403	0	9. 00
10.00	01000 DI ETARY	0	0	0	297, 274	23, 520	
13.00	01300 NURSING ADMINISTRATION	0	0	25, 440	30, 665	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	15, 651	104, 436	9, 228	14. 00
15. 00	O1500 PHARMACY	0	0	61, 195	133, 830	0	15. 00
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0	386, 037	1, 928, 079	186, 467	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	93, 244	438, 508	38, 664	31. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	75, 244	430, 300	0	40.00
41. 00	04100 SUBPROVI DER – I RF	0	o	43, 629	418, 269	19, 884	41. 00
42.00	04200 SUBPROVI DER	0	0	0	O	0	42. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	O	ol	107.070	1 527 705	107 150	F0 00
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	0	127, 978	1, 536, 705 0	107, 159 0	50. 00 51. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	96, 105	948, 158	50, 378	54. 00
57. 00	05700 CT SCAN	0	o	18, 600	66, 630	11, 601	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	10, 636	194, 678	146	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	23, 900	220, 787	7, 541	59. 00
60. 00	06000 LABORATORY	0	0	116, 705	511, 885	146	60.00
60. 01	06001 ONCOLOGY	0	0	0	0	7, 326	60. 01
60. 02 65. 00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	0	0	42, 745	201, 205	0 8, 329	60. 02 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	26, 260	38, 594	17, 352	
69. 00	06900 ELECTROCARDI OLOGY	0	Ö	33, 516	353, 566	5, 138	
69. 01	06901 CARDI AC REHAB	0	0	4, 956	56, 818	57	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. 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
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	7, 255	124, 061	3, 869	90. 00
91. 00	09100 EMERGENCY	o	Ö	155, 177	485, 644	87, 586	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	E2 142	181, 930	24 404	95. 00
93.00	SPECIAL PURPOSE COST CENTERS	j dj	<u> </u>	52, 143	101, 930	26, 694	95.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00		0	1, 505, 443	1, 371, 917	8, 510, 733	611, 085	118. 00
400.00	NONREI MBURSABLE COST CENTERS		اه	704	F0.000		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	784	59, 008		190. 00 192. 00
	19202 VI SI TOR MEALS	o o	123, 747	0	ol		192. 02
	19203 GREAT BEGINNINGS/MATERNAL	0	0	0	О		192. 03
	19204 LI FELI NE	0	0	0	0		192. 04
	19205 OWNED PROPERTIES	0	0	0	0		192. 05
	19211 PARI SH NURSI NG	0	0	1, 467	14, 982		192. 08 192. 09
	19212 BIOTERRORISM GRANT 19214 BREAST PUMPS	0	0	23	263		192. 09
	19210 MGH PHYS PRACT MGMT	0	0	58, 618	203		192. 14
	19215 MGH MARION SURGEONS	o	Ö	20, 085	o		192. 15
192. 16	19216 MGH MGH MED ONC	0	0	0	0	0	192. 16
	19217 MGH FMC SOUTH	0	0	0	0		192. 17
	19218 MGH FAIRM MED ASSOC	0	0	0	0		192. 18
	19219 MGH FMC MARION	0	0	19, 083	0		192. 19
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD		0	0	0		193. 00 193. 01
	19302 MGH FMC NORTHWOOD		0	0	ol Ol		193. 01
	19303 MGH HOSPI TALI STS		o	0	o		193. 03
193. 04	19304 MGH MAR FAM PRACT	0	0	0	o	760	193. 04
	19305 MGH FMC SWAYZEE	0	0	0	0		193. 05
	19306 MGH PEDIATRIC CTR	0	0	15, 225	0		193. 06
	19307 MGH SPECIALTY PHYS 19308 MGH FMC CONVERSE		0	5, 502 0	0		193. 07 193. 08
	19309 MGH UPLAND HEALTH		0	0	ol Ol		193. 06
	1	<u>, </u>	91		<u> </u>		· · · · · · ·

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

Provider CCN: 150011

					11/20/2014 2:	46 pm
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6. 01	6. 02	7. 00	8. 00	
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHLATRY	0	0	4, 893	0	0	193. 11
193. 12 19312 OB/GYN	0	0	0	0	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	194. 00
194. 01 07950 MOW	0	0	0	0	0	194. 01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	7, 846	0	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	574	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	1, 629, 190	1, 505, 443	8, 584, 986	615, 025	202. 00

Provider CCN: 150011

| Period: | Worksheet B | From 07/01/2013 | Part | To 06/30/2014 | Date/Time Prepared:

				T	06/30/2014		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	11/20/2014 2: PHARMACY	46 piii
		9. 00	10.00	13.00	14. 00	15. 00	
1. 00 4. 00 5. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00	GENERAL SERVI CE 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 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	3, 127, 318 45, 119 14, 100 70, 499 45, 119	1, 312, 427 0 0 0	1, 481, 619	1, 253, 495 0	4, 615, 912	1. 00 4. 00 5. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00
30. 00 31. 00 40. 00 41. 00 42. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	654, 226 180, 476 0 157, 917 0	790, 221 131, 409 0 118, 077 0	98, 881 0	240, 721 124, 726 0 0 0 0	0 0 0 0 0	30. 00 31. 00 40. 00 41. 00 42. 00 43. 00
50. 00 51. 00 54. 00 57. 00 58. 00 59. 00 60. 01 60. 02 65. 00	ANCILLARY SERVICE COST CENTERS 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	462, 471 0 140, 997 8, 460 0 56, 399 157, 917 0 0 118, 438	0 0 0 0 0 0 0	135, 714 0 101, 914 19, 725 11, 279 25, 344 145, 637 43, 803 0 53, 415	0 12, 473 0 0 0 62, 363 3, 742	0 0 0 0 0 0 0 0	50. 00 51. 00 54. 00 57. 00 58. 00 59. 00 60. 00 60. 01 60. 02 65. 00
66. 00 69. 00 69. 01 71. 00 72. 00 73. 00	06500 PHYSICAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	76, 138 84, 598 0 0 0	000000000000000000000000000000000000000	55, 415 51, 227 35, 542 5, 255 0 0 0	0 4, 989 0 0 0 0	0 0 0 0 0 4, 615, 912	66. 00 69. 00 69. 01 71. 00 72. 00 73. 00
91. 00 91. 00 92. 00 92. 01	09100 ELINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	631, 667	14, 480 0		124, 726 0	0	90.00 91.00 92.00 92.01
95. 00	09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	19, 740	0	55, 295	0	0	95. 00
113. 00 118. 00	11300 INTEREST EXPENSE	2, 980, 680	1, 054, 187	1, 475, 816	1, 045, 201	4, 615, 912	113. 00 118. 00
192. 00 192. 01 192. 0 192. 0 192. 0 192. 0 192. 0 192. 1 192. 1 192. 1 192. 1 192. 1 193. 0 193. 0 193. 0 193. 0 193. 0 193. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19202 VI SI TOR MEALS 19203 GREAT BEGINNI NGS/MATERNAL 19204 LI FELI NE 19205 OWNED PROPERTI ES 19212 BI OTERRORI SM GRANT 19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS 19215 MGH PHYS PRACT MGMT 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARI ON 19300 NONPAID WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CI TY 19304 MGH MAR FAM PRACT 19305 MGH FMC SWAYZEE 19306 MGH PEDI ATRI C CTR 19307 MGH SPECI ALTY PHYS 19308 MGH FMC CONVERSE	5, 640 0 0 0 0 0 0 5, 640 0 22, 560 0 0 112, 798 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 5, 779 0 0 0 24 0 0 0 0 0 0 0 0 0	0 0 0 0 0 37, 418 0 2, 495 0 12, 473 0 12, 473 12, 473 12, 473	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190. 00 192. 00 192. 02 192. 03 192. 03 192. 04 192. 05 192. 09 192. 10 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00 193. 01 193. 02 193. 03 193. 04 193. 05 193. 06 193. 06 193. 07 193. 08

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MARION GENERAL HOSPITAL Provider CCN: 150011

					11/20/2014 2:46 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY
			ADMI NI STRATI ON	SERVICES &	
				SUPPLY	
	9. 00	10.00	13. 00	14. 00	15. 00
193.09 19309 MGH UPLAND HEALTH	0	0	0	49, 890	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	6, 236	0 193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0 193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0 194. 00
194. 01 07950 MOW	0	174, 633	0	0	0 194. 01
194.02 07951 MENTAL HEALTH	0	83, 607	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	6, 236	0 194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0 194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0 194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	O	0 194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	O	0 194. 10
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	3, 127, 318	1, 312, 427	1, 481, 619	1, 253, 495	4, 615, 912 202. 00

Provider CCN: 150011

Peri od: Worksheet B
From 07/01/2013 Part I

					From 07/01/2013 Part 1 Fo 06/30/2014 Date/Time Pr	
	Cost Center Description	Subtotal	Intern &	Total	11/20/2014 2	: 46 pm
			Residents Cost			
			& Post Stepdown			
			Adjustments			
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS					5. 00 6. 00
6. 01	00601 CAFETERI A					6. 01
6. 02 7. 00	OO6O2 CAFETERI A OO7OO OPERATI ON OF PLANT					6. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10. 00 13. 00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON					10. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	20, 331, 265	ol	20, 331, 265	5	30.00
31. 00	03100 INTENSIVE CARE UNIT	5, 869, 504	1	5, 869, 504	1	31. 00
40. 00 41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF	2 521 504	1 "1	3, 531, 58 ²		40. 00 41. 00
	04200 SUBPROVI DER	3, 531, 584		3, 331, 362		42.00
43. 00	04300 NURSERY	1, 649, 780	o o	1, 649, 780	D	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	14, 660, 607	'l ol	14, 660, 607	7	50.00
51. 00	05100 RECOVERY ROOM	c	o	(D	51. 00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	8, 114, 949 1, 332, 317	1	8, 114, 949 1, 332, 317		54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 048, 763	1	1, 048, 763		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 541, 170	1	4, 541, 170		59. 00
60. 00 60. 01	06000 LABORATORY 06001 0NC0LOGY	10, 629, 904 2, 169, 608	1	10, 629, 90 ² 2, 169, 608		60. 00 60. 01
60. 02	06002 RADI ATI ON ONCOLOGY	2, 107, 000	o o	2, 107, 000		60. 02
65. 00	06500 RESPI RATORY THERAPY	3, 467, 391	1	3, 467, 391		65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	3, 080, 239 2, 008, 114	1	3, 080, 239 2, 008, 114		66. 00 69. 00
69. 01	06901 CARDI AC REHAB	404, 198	o	404, 198	3	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0 0	()	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	12, 152, 845	1	12, 152, 845	5	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	7/0 0/1	'l ol	7/0 0/1	7	00.00
90. 00 91. 00	09100 EMERGENCY	760, 847 8, 863, 145	-	760, 847 8, 863, 145		90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		o			92. 00
92. 01	O9201 OBSERVATION BEDS (DISTINCT PART)	C	0	()	92. 01
95. 00	09500 AMBULANCE SERVICES	1, 932, 716	0	1, 932, 716	5	95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE					112 00
118.00	1 I	106, 548, 946	ol	106, 548, 946	5	113. 00 118. 00
400.00	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	162, 077	1	162, 077		190. 00 192. 00
192. 02	19202 VISITOR MEALS	123, 747	o	123, 747	7	192. 02
	19203 GREAT BEGINNINGS/MATERNAL	214, 291	1	214, 291		192. 03 192. 04
	19204 LI FELI NE 19205 OWNED PROPERTI ES	661, 655	1	661, 655	1	192. 04
192. 08	19211 PARI SH NURSI NG	126, 107	o	126, 107	7	192. 08
	19212 BIOTERRORISM GRANT 19214 BREAST PUMPS	60, 935 3, 828	1	60, 935 3, 828		192. 09 192. 10
	19210 MGH PHYS PRACT MGMT	2, 190, 657	1	2, 190, 657		192. 14
	19215 MGH MARI ON SURGEONS	2, 615, 082	1	2, 615, 082		192. 15
	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	1, 135, 071 2, 916, 563	- 1	1, 135, 071 2, 916, 563		192. 16 192. 17
192. 18	19218 MGH FAIRM MED ASSOC	658, 656	o	658, 656	5	192. 18
	19219 MGH FMC MARION 19300 NONPAID WORKERS	1, 077, 452	0	1, 077, 452	2	192. 19 193. 00
	19301 MGH FMC NORTHWOOD	987, 695	- 1	987, 695	5	193. 00
	19302 MGH FMC GAS CITY	1, 033, 544	1	1, 033, 544		193. 02
	19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	2, 952, 013 2, 791, 554	1	2, 952, 013 2, 791, 554		193. 03 193. 04
193.05	19305 MGH FMC SWAYZEE	210, 658	o	210, 658	3	193. 05
193. 06	19306 MGH PEDIATRIC CTR	1, 280, 777	'l ol	1, 280, 777	7	193. 06

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

Provider CCN: 150011

				11	11/20/2014 2: 46 pm
	Cost Center Description	Subtotal	Intern &	Total	117,207,2011, 217,0 p
	·		Residents Cost		
			& Post		
			Stepdown		
			Adjustments		
		24.00	25. 00	26.00	
193. 07 19307 [MGH SPECIALTY PHYS	394, 135	0	394, 135	193. 07
193. 08 19308 1	MGH FMC CONVERSE	306, 380	0	306, 380	193. 08
193. 09 19309 [MGH UPLAND HEALTH	1, 540, 531	0	1, 540, 531	193. 09
193. 10 19310 [MGH MGH WOMENS CTR	0	0	0	193. 10
193. 11 19311 [MGH MGH PSYCHLATRY	621, 452	0	621, 452	193. 11
193. 12 19312	OB/GYN	2, 794, 903	0	2, 794, 903	193. 12
193. 15 19315 [MGH RIVER VIEW BLDG	0	0	0	193. 15
194.00 07963	OTHER NONREIMBURSABLE	0	0	0	194. 00
194. 01 07950 [MOW	174, 633	0	174, 633	194. 01
194. 02 07951 [MENTAL HEALTH	83, 607	0	83, 607	194. 02
194. 03 07952	ADVERTI SI NG	449, 554	0	449, 554	194. 03
194. 04 07953 [MGH WORK SOLUTIONS	1, 001, 642	0	1, 001, 642	194. 04
194. 05 07954 [MGH TAYLOR UNIVERSITY	199, 326	0	199, 326	194. 05
194. 08 07957 [MGH SMMP BLDG	305, 865	0	305, 865	194. 08
194. 09 07958 [MGH AMBUCARE BLDG	70, 826	0	70, 826	194. 09
194. 10 07959 [MGH 106 LYONS BLDG	13, 333	0	13, 333	194. 10
200.00	Cross Foot Adjustments	0	0	0	200. 00
201.00	Negative Cost Centers	0	0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	135, 707, 495	0	135, 707, 495	202. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION STATISTICS	Provi der CCN: 150011	Period: Worksheet Non-CMS W
		From 07/01/2013
		To 04/20/2014 Doto/Timo Droparod.

		1	11/20/2014 11/20/2014 2:	
	Cost Center Description	Stati sti cs	Statistics Description	
		Code	·	
		1. 00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1		1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S		4.00
5.00	ADMINISTRATIVE & GENERAL	-73		5. 00
6.00	MAINTENANCE & REPAIRS	1		6. 00
6. 01	CAFETERI A	71		6. 01
6.02	CAFETERI A	72		6. 02
7.00	OPERATION OF PLANT	1		7. 00
8.00	LAUNDRY & LINEN SERVICE	8		8. 00
9.00	HOUSEKEEPI NG	9		9. 00
10.00	DI ETARY	10		10.00
13.00	NURSING ADMINISTRATION	13		13. 00
14.00	CENTRAL SERVICES & SUPPLY	14		14. 00
15.00	PHARMACY	15		15. 00

| Peri od: | Worksheet B | From 07/01/2013 | Part | I | To 06/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150011

					To	06/30/2014	Date/Time Pre 11/20/2014 2:	
				CAPI TAL				,
		Cost Center Description	Di rectly	RELATED COSTS NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		cost center bescription	Assigned New	FIXT	Subtotal	BENEFITS	& GENERAL	
			Capi tal			DEPARTMENT		
			Related Costs 0	1 00	24	4.00	E 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2A	4. 00	5. 00	
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	394, 934		394, 934		4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0	1, 810, 954 0		61, 596 0	1, 872, 550 0	5. 00 6. 00
6. 01		CAFETERI A	0	147, 154	-	0	22, 480	6. 01
6. 02	1	CAFETERI A	0	0	0	0	0	6. 02
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	2, 898, 019		3, 841 0	118, 033	7. 00 8. 00
9.00		HOUSEKEEPING		64, 247 101, 568	64, 247 101, 568	0	7, 208 41, 131	9. 00
10. 00	1	DI ETARY	0	206, 235		0	13, 060	
13.00		NURSING ADMINISTRATION	0	21, 274		6, 982		13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	72, 453 92, 845		1, 953 18, 959		14. 00 15. 00
13.00		LENT ROUTINE SERVICE COST CENTERS		72, 043	72, 043	10, 737	37, 402	13.00
30.00		ADULTS & PEDIATRICS	0	.,		67, 046		30. 00
31.00		I NTENSI VE CARE UNI T	0	304, 217	304, 217	20, 773		31.00
40. 00 41. 00		SUBPROVI DER	0	290, 176	290, 176	8, 223	0 37, 635	40. 00 41. 00
42. 00		SUBPROVI DER	0	0		0	0	42. 00
43. 00		NURSERY	0	0	0	7, 598	22, 764	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	1, 066, 095	1, 066, 095	25, 699	163, 771	50. 00
51. 00		RECOVERY ROOM	0	1,000,073		23, 077		51. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	657, 788		19, 388		54. 00
57. 00	1	CT SCAN	0	46, 225		3, 570		57. 00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	135, 059 153, 172		2, 042 4, 740		
60. 00		LABORATORY	0	355, 122		20, 931		60.00
60. 01	1	ONCOLOGY	0	0	-	7, 881	29, 180	
60. 02 65. 00	1	RADIATION ONCOLOGY RESPIRATORY THERAPY	0	120 507		10 544	1	60. 02 65. 00
66. 00		PHYSICAL THERAPY		139, 587 26, 775		10, 544 11, 834		66. 00
69. 00		ELECTROCARDI OLOGY	0	245, 288		5, 919		69. 00
69. 01		CARDI AC REHAB	0	39, 417		931		69. 01
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	-	0	0	71. 00 72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0		0		73. 00
	OUTPA	TIENT SERVICE COST CENTERS						
90. 00 91. 00		CLINIC EMERGENCY	0	86, 068 336, 918		1, 634 30, 314		90. 00 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART)		330, 910	330, 910	30, 314	99, 330	91.00
92. 01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
05.00		REIMBURSABLE COST CENTERS	1 0	12/ 215	12/ 215	7.0/5	1 22 025	05 00
95.00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	0	126, 215	126, 215	7, 065	22, 035	95.00
113.00		I NTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	11, 155, 416	11, 155, 416	349, 463	1, 483, 383	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	Ι ο	40, 937	40, 937	165	1 334	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	1	VISITOR MEALS	0	0	0	0		192. 02
	1	GREAT BEGINNINGS/MATERNAL	0	0	0	1, 071		192. 03
	1	LIFELINE OWNED PROPERTIES	0	0		0		192. 04 192. 05
		PARI SH NURSI NG	0	10, 394		322		192. 08
	1	BIOTERRORISM GRANT	0	0	0	162		192. 09
	1	BREAST PUMPS MGH PHYS PRACT MGMT	0	182		10 8, 649		192. 10
		MGH MARION SURGEONS	0	0	0	2, 790		
	1	MGH MGH MED ONC	0	0	0	0		
	1	MGH FMC SOUTH	0	0	0	5, 016		
	1	MGH FAIRM MED ASSOC MGH FMC MARION	0	0	0	1, 040 2, 110		192. 18 192. 19
	1	NONPAID WORKERS		o o	0	2, 110		193. 00
193. 01	19301	MGH FMC NORTHWOOD	0	0	0	1, 674	13, 456	193. 01
		MGH FMC GAS CITY MGH HOSPITALISTS	0	0	0	1, 486 267		
		MGH HUSPITALISTS MGH MAR FAM PRACT	0	0	0	5, 729		
	1	MGH FMC SWAYZEE	0	ō		407		193. 05

| Peri od: | Worksheet B | From 07/01/2013 | Part | I | To 06/30/2014 | Date/Time Prepared: Provider CCN: 150011

				10 00/00/2011	11/20/2014 2:	
		CAPI TAL				
		RELATED COSTS	1			
Cost Center Description	Di rectly	NEW BLDG &	Subtotal		ADMI NI STRATI VE	
	Assi gned New	FLXT		BENEFITS	& GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs		0.4	4.00	F 00	
100 0/1000/1001 PERLATRIO OTR	0	1.00	2A	4.00	5. 00	100.01
193. 06 19306 MGH PEDIATRIC CTR		0		0 1, 695		193. 06
193. 07 19307 MGH SPECIALTY PHYS		0		0 671	1	193. 07
193. 08 19308 MGH FMC CONVERSE		0		0 610		193. 08
193. 09 19309 MGH UPLAND HEALTH		0		0 2, 982		
193. 10 19310 MGH MGH WOMENS CTR		0		0	l	193. 10
193. 11 19311 MGH MGH PSYCHIATRY		0		0 536		193. 11
193. 12 19312 OB/GYN		0		0 3, 490		193. 12
193.15 19315 MGH RIVER VIEW BLDG) 0		0 0	1	193. 15
194.00 07963 OTHER NONREIMBURSABLE	C	0		0	l	194. 00
194. 01 07950 MOW	C	0		0		194. 01
194.02 07951 MENTAL HEALTH	C	0		0		194. 02
194. 03 07952 ADVERTI SI NG	() 0		0 1, 576		194. 03
194.04 07953 MGH WORK SOLUTIONS	C) 0		0 2, 603		•
194.05 07954 MGH TAYLOR UNIVERSITY	() 0		0 410	2, 750	194. 05
194.08 07957 MGH SMMP BLDG	(C	0		0		194. 08
194.09 07958 MGH AMBUCARE BLDG	(0		0	l	194. 09
194.10 07959 MGH 106 LYONS BLDG	(0		0	184	194. 10
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0		201. 00
202.00 TOTAL (sum lines 118-201)	0	11, 206, 929	11, 206, 92	9 394, 934	1, 872, 550	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared: |

				'	0 06/30/2014	Date/lime Pre	
	Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	J
		REPAI RS	/ 01	4 02	PLANT	LINEN SERVICE	
	GENERAL SERVICE COST CENTERS	6. 00	6. 01	6. 02	7. 00	8. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0					6. 00
6. 01	00601 CAFETERI A	0	169, 634				6. 01
6. 02	00602 CAFETERI A	0	156, 749				6. 02
7.00	00700 OPERATION OF PLANT	0	(1 0, 20.			7.00
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	0	(,	104, 066	8. 00 9. 00
10.00	01000 DI ETARY	0	(51, 554 104, 681	3, 980	1
13. 00	01300 NURSING ADMINISTRATION	0	(2, 649			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	(14. 00
15. 00	01500 PHARMACY	0	C		1		1
	INPATIENT ROUTINE SERVICE COST CENTERS				, .=.		
30.00	03000 ADULTS & PEDIATRICS	0	C	40, 194	678, 948	31, 550	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	C	9, 709	154, 415	6, 542	31. 00
40.00	04000 SUBPROVI DER - I PF	0	C) (0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	C	4, 543	147, 288	3, 365	1
42. 00	04200 SUBPROVI DER	0	C		0	0	42.00
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	C) (0	0	43. 00
50. 00	05000 OPERATING ROOM	0	(13, 325	541, 131	18, 132	50.00
51. 00	05100 RECOVERY ROOM	0	() 341, 131	l .	51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	(1	_	_	54.00
57. 00	05700 CT SCAN	0	C		1		1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	2, 488	77, 747	1, 276	59. 00
60.00	06000 LABORATORY	0	C	12, 152	180, 254		60.00
60. 01	06001 ONCOLOGY	0	C	0	0	1, 240	1
60. 02	06002 RADI ATI ON ONCOLOGY	0	C	1	0	0	60. 02
65. 00	06500 RESPIRATORY THERAPY	0	C	1 .,			65.00
66. 00 69. 00	O6600 PHYSI CAL THERAPY O6900 ELECTROCARDI OLOGY	0	(2, 734 3, 490			66. 00 69. 00
69. 00	06901 CARDI AC REHAB	0	(516			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(310	20,000	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C			o o	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C		Ö	Ō	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	C	755	43, 687	655	90. 00
91. 00	09100 EMERGENCY	0	C	16, 157	171, 013	14, 820	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0) () 0	0	92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	C	L 420	64.064	/ E17	95. 00
95.00	SPECIAL PURPOSE COST CENTERS	U		5, 429	64, 064	4, 517	95.00
113 00	11300 I NTEREST EXPENSE						113. 00
118. 00	1	0	156, 749	142, 846	2, 996, 946	103, 399	
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	82	20, 779	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	C) (0		192. 00
	19202 VISITOR MEALS	0	12, 885	6	0		192. 02
	19203 GREAT BEGINNI NGS/MATERNAL	0	C		0		192. 03
	19204 LI FELI NE	0	(0		192. 04
	19205 OWNED PROPERTIES 19211 PARISH NURSING	0	(1 = 3) U		192. 05
	19211 PARISH NURSING 19212 BIOTERRORISM GRANT	0	(153	5, 276		192. 08 192. 09
	19214 BREAST PUMPS	0	(93		192. 10
	19210 MGH PHYS PRACT MGMT	0	(6, 103			192. 14
	19215 MGH MARION SURGEONS	0	C	2, 091			192. 15
	19216 MGH MGH MED ONC	0	Č		0		192. 16
192. 17	19217 MGH FMC SOUTH	0	C) (0	9	192. 17
192. 18	19218 MGH FAIRM MED ASSOC	0	C) (0	7	192. 18
192. 19	19219 MGH FMC MARION	0	C	1, 987	0	114	192. 19
	19300 NONPALD WORKERS	0	C) (0		193. 00
	19301 MGH FMC NORTHWOOD	0	C		0	l .	193. 01
	19302 MGH FMC GAS CITY	0	(0	l .	193. 02
	19303 MGH HOSPI TALI STS	0	(0		193. 03
	19304 MGH MAR FAM PRACT 19305 MGH FMC SWAYZEE	0	(193. 04 193. 05
	19305 MGH FMC SWAYZEE		(1, 585	, 0		193. 05
	19307 MGH SPECIALTY PHYS		(573		l .	193. 00
	19308 MGH FMC CONVERSE	0	(193. 08
	19309 MGH UPLAND HEALTH	0	C	1	_		193. 09
				-			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MARION GENERAL HOSPITAL

| Peri od: | Worksheet B | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared: | 11/20/2014 2:46 pm Provider CCN: 150011

					11/20/2014 2:	46 pm_
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6. 01	6. 02	7. 00	8. 00	
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHLATRY	0	0	510	0	0	193. 11
193. 12 19312 OB/GYN	0	0	0	0	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
194. 00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	194. 00
194. 01 07950 MOW	0	0	0	0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	0	0	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	817	0	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	97	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194. 08
194.09 07958 MGH AMBUCARE BLDG	o	0	0	0	0	194. 09
194. 10 07959 MGH 106 LYONS BLDG	o	0	0	0	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	o	169, 634	156, 749	3, 023, 094	104, 066	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2013 | Part II | To 06/30/2014 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011

			10	06/30/2014	Date/lime Pre 11/20/2014 2:	
Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG	CENTRAL	PHARMACY	ТО рін
			ADMI NI STRATI ON	SERVICES &		
	9. 00	10.00	13. 00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	7.00	10.00	13.00	14.00	13.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
6. 01 00601 CAFETERI A 6. 02 00602 CAFETERI A						6. 01 6. 02
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG	194, 253					9. 00
10. 00 01000 DI ETARY	2, 803	330, 759				10. 00
13.00 01300 NURSING ADMINISTRATION	876	0	62, 054			13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	4, 379	0	-	133, 291		14. 00
15. 00 01500 PHARMACY	2, 803	0	2, 718	0	230, 306	15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	40, 639	199, 152	17, 147	25, 597	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	11, 210	33, 118		13, 263	0	31.00
40. 00 04000 SUBPROVI DER - PF	0	00, 110	0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	9, 809	29, 758	1, 938	0	0	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
ANCI LLARY SERVI CE COST CENTERS	00.70/					
50. 00 05000 0PERATI NG ROOM	28, 726	0	5, 684 0	44, 830	0	50.00
51. 00 05100 RECOVERY ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 8, 758	0	4, 268	1, 326	0	51. 00 54. 00
57. 00 05700 CT SCAN	525	0	826	1, 320	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	472	o	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 503	0	1, 061	0	0	59. 00
60. 00 06000 LABORATORY	9, 809	0	6, 100	6, 631	0	60.00
60. 01 06001 0NCOLOGY	0	0	1, 835	398	0	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0	0	0	0	60. 02
65. 00 06500 RESPIRATORY THERAPY	7, 357	0	2, 237	5, 305	0	65.00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0 4, 729	0	2, 145 1, 489	531	0	66. 00 69. 00
69. 01 06901 CARDI AC REHAB	5, 255	0	220	0	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 200	0	0	o	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	230, 306	73. 00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	3, 503	0		0	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	39, 236	3, 649	6, 892	13, 263	0	91. 00 92. 00
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	91		<u> </u>	<u> </u>		,2.0.
95. 00 09500 AMBULANCE SERVICES	1, 226	0	2, 316	0	0	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE	105 111	0/5/77				113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	185, 146	265, 677	61, 811	111, 144	230, 306	1118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	350	0		٥	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	Ö	0		192. 00
192. 02 19202 VI SI TOR MEALS	o	0	0	Ö		192. 02
192.03 19203 GREAT BEGINNINGS/MATERNAL	0	0	242	0	0	192. 03
192. 04 19204 LI FELI NE	0	0	0	0		192. 04
192. 05 19205 OWNED PROPERTIES	0	0	0	0		192. 05
192. 08 19211 PARI SH NURSI NG	350	0	0	0		192. 08
192.09 19212 BIOTERRORISM GRANT 192.10 19214 BREAST PUMPS	0	0	0	O O		192. 09 192. 10
192. 10 19214 BREAST POWPS 192. 14 19210 MGH PHYS PRACT MGMT	1, 401	0	0	0		192. 10
192. 15 19215 MGH MARI ON SURGEONS	1, 431	0	Ö	3, 979		192. 15
192. 16 19216 MGH MGH MED ONC	o	0	Ö	0		192. 16
192.17 19217 MGH FMC SOUTH	7, 006	0	0	265		192. 17
192.18 19218 MGH FAIRM MED ASSOC	0	0	0	0		192. 18
192. 19 19219 MGH FMC MARI ON	0	0	0	1, 326		192. 19
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 MGH FMC NORTHWOOD	0	0		1, 326		193. 01 193. 02
193.02 19302 MGH FMC GAS CLTY 193.03 19303 MGH HOSPITALISTS		0		1, 326		193. 02
193.04 19304 MGH MAR FAM PRACT		0		3, 979		193. 03
193. 05 19305 MGH FMC SWAYZEE		Ö	l ől	1, 326		193. 05
193.06 19306 MGH PEDIATRIC CTR	0	0	O	1, 326	0	193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	0	0	o		193. 07
193. 08 19308 MGH FMC CONVERSE	0	0	0	663	0	193. 08

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MARION GENERAL HOSPITAL

Provider CCN: 150011

					11/20/2014 2:46 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY
			ADMI NI STRATI ON	SERVICES &	
				SUPPLY	
	9. 00	10.00	13. 00	14. 00	15. 00
193.09 19309 MGH UPLAND HEALTH	0	0	0	5, 305	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	663	0 193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0 193. 15
194. 00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0 194. 00
194. 01 07950 MOW	0	44, 011	0	0	0 194. 01
194.02 07951 MENTAL HEALTH	0	21, 071	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	663	0 194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0 194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0 194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	O	0 194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	O	0 194. 10
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118-201)	194, 253	330, 759	62, 054	133, 291	230, 306 202. 00

| Peri od: | Worksheet B | From 07/01/2013 | Part | I | To 06/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011

			To	06/30/2014 Date/Time Pr 11/20/2014 2	
Cost Center Description	Subtotal	Intern &	Total	, , , , , , , , , ,	
		Residents Cost & Post			
		Stepdown			
		Adj ustments			
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00 O0100 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 6.01 00601 CAFETERIA					6. 00 6. 01
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 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9. 00 10. 00
13. 00 01300 NURSI NG ADMINI STRATI ON					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 655, 043	ol	2, 655, 043		30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	623, 117	0	623, 117		31. 00
40. 00 04000 SUBPROVI DER - PF	0	Ö	0		40. 00
41. 00 04100 SUBPROVI DER - I RF	532, 735	0	532, 735		41. 00
42. 00 04200 SUBPROVI DER	0	0	0		42. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	30, 362	0	30, 362		43. 00
50. 00 05000 OPERATI NG ROOM	1, 907, 393	0	1, 907, 393		50.00
51.00 05100 RECOVERY ROOM	O	0	0		51. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 137, 285	0	1, 137, 285		54.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	95, 168 218, 738	0	95, 168 218, 738		57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	302, 039	o	302, 039		59. 00
60. 00 06000 LABORATORY	723, 973	0	723, 973		60.00
60. 01 06001 0NCOLOGY	40, 534	0	40, 534		60. 01
60. 02 06002 RADI ATI ON ONCOLOGY 65. 00 06500 RESPI RATORY THERAPY	0 283, 045	0	0 283, 045		60. 02 65. 00
66. 00 06600 PHYSI CAL THERAPY	100, 675	0	100, 675		66. 00
69. 00 06900 ELECTROCARDI OLOGY	407, 506	O	407, 506		69. 00
69. 01 06901 CARDI AC REHAB	69, 841	0	69, 841		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	334, 302	0	334, 302		73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	144, 373	0	144, 373		90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	731, 600	0	731, 600		91. 00 92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0		92. 01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	232, 867	0	232, 867		95. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10, 570, 596	0	10, 570, 596		118. 00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	63, 647	0	63, 647		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 02 19202 VESI TOR MEALS	0 12, 885	0	0 12, 885		192. 00 192. 02
192. 03 19203 GREAT BEGINNINGS/MATERNAL	4, 190	o	4, 190		192. 03
192. 04 19204 LI FELI NE	0	0	0		192. 04
192. 05 19205 OWNED PROPERTIES	9, 130	0	9, 130		192. 05
192. 08 19211 PARI SH_NURSI NG 192. 09 19212 BI OTERRORI SM_GRANT	17, 930 1, 003	0	17, 930 1, 003		192. 08 192. 09
192. 10 19214 BREAST PUMPS	337	o	337		192. 10
192.14 19210 MGH PHYS PRACT MGMT	45, 260	0	45, 260		192. 14
192. 15 19215 MGH MARI ON SURGEONS	44, 150	0	44, 150		192. 15
192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH	15, 662 50, 948	0	15, 662 50, 948		192. 16 192. 17
192. 17 19217 MGH FMC 3001H 192. 18 19218 MGH FAIRM MED ASSOC	10, 135	0	10, 135		192. 17
192. 19 19219 MGH FMC MARION	19, 959	Ö	19, 959		192. 19
193. 00 19300 NONPALD WORKERS	0	0	0		193. 00
193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY	16, 456 16, 968	0	16, 456 16, 968		193. 01 193. 02
193.02 19302 MGH FMC GAS CITY 193.03 19303 MGH HOSPITALISTS	41, 000	0	41, 000		193. 02
193. 04 19304 MGH MAR FAM PRACT	47, 829	o	47, 829		193. 04
193. 05 19305 MGH FMC SWAYZEE	4, 468	0	4, 468		193. 05
193.06 19306 MGH PEDIATRIC CTR	21, 961	0	21, 961		193. 06

Provider CCN: 150011

				11	0 06/30/2014 Date/IIme Prepared 11/20/2014 2:46 pm	
Cost	t Center Description	Subtotal	Intern &	Total	117 207 2011 21 10 pm	
	'		Residents Cost			
			& Post			
			Stepdown			
			Adjustments			
		24.00	25. 00	26. 00		
193. 07 19307 MGH	SPECIALTY PHYS	6, 607	0	6, 607	193. (07
193.08 19308 MGH	FMC CONVERSE	5, 432	0	5, 432	193. (80
193. 09 19309 MGH	UPLAND HEALTH	28, 990	0	28, 990	193. (09
193. 10 19310 MGH	MGH WOMENS CTR	0	0	0	193.	10
193. 11 19311 MGH	MGH PSYCHIATRY	9, 553	0	9, 553	193.	11
193. 12 19312 OB/G	GYN	42, 632	0	42, 632	193.	12
193. 15 19315 MGH	RIVER VIEW BLDG	0	0	0	193.	15
194. 00 07963 OTHE	ER NONREI MBURSABLE	0	0	0	194. (00
194.01 07950 MOW		44, 011	0	44, 011	194. (01
194. 02 07951 MENT	ΓAL HEALTH	21, 071	0	21, 071	194. (02
194. 03 07952 ADVE	ERTI SI NG	8, 488	0	8, 488	194. (03
194.04 07953 MGH	WORK SOLUTIONS	17, 090	0	17, 090	194. (04
194.05 07954 MGH	TAYLOR UNIVERSITY	3, 160	0	3, 160	194. (05
194.08 07957 MGH	SMMP BLDG	4, 220	0	4, 220	194. (80
194.09 07958 MGH	AMBUCARE BLDG	977	0	977	194. (09
194. 10 07959 MGH	106 LYONS BLDG	184	0	184	194.	10
200.00 Cros	ss Foot Adjustments	0	0	0	200. (00
201. 00 Nega	ative Cost Centers	0	0	0	201. (00
202. 00 TOTA	AL (sum lines 118-201)	11, 206, 929	0	11, 206, 929	202. (00

	Financial Systems	MARTON GENERA		0011 450044 5		eu of Form CMS	
COST A	ILLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 07/01/2013 o 06/30/2014		pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
	T	1.00	4. 00	5A	5. 00	6. 00	
	GENERAL SERVICE COST CENTERS	0.0 755		1	T		
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	368, 755 12, 995	47 (25 402				1. 00 4. 00
5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	59, 588	47, 625, 403 7, 427, 484	1	114, 730, 878		5.00
6. 00	00600 MAI NTENANCE & REPAI RS	37, 300	7, 427, 404) -20, 970, 017	114, 730, 676	296, 172	
6. 01	00601 CAFETERI A	4, 842	0	Ö	1, 377, 363		1
6. 02	00602 CAFETERI A	0	0	0	0	0	
7.00	00700 OPERATION OF PLANT	95, 357	463, 117		7, 231, 994		
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	2, 114	0		441, 666		1
10.00	01000 DI ETARY	3, 342 6, 786	0		2, 520, 149 800, 209		1
13. 00	01300 NURSING ADMINISTRATION	700	841, 856				1
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 384	235, 444			l .	1
15. 00	01500 PHARMACY	3, 055	2, 286, 195	<u> </u>	3, 644, 533	3, 055	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14 040	0.007.005	.1	10 000 747	14.040	1 00 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	44, 013 10, 010	8, 087, 905 2, 504, 940				1
40. 00	04000 SUBPROVI DER - I PF	10,010	2, 504, 940			10,010	1
41. 00	04100 SUBPROVI DER - I RF	9, 548	991, 526				1
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	0	916, 152	! C	1, 394, 770	0	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	25 070	2 000 045		10 024 201	25.070	FO 00
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	35, 079	3, 098, 845			35, 079 0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	21, 644	2, 337, 914			_	1
57. 00	05700 CT SCAN	1, 521	430, 497				
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 444	246, 188	S C	703, 416	4, 444	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 040	571, 559	1	3, 556, 883		1
60.00	06000 LABORATORY	11, 685	2, 523, 880	1	-,,		1
60. 01 60. 02	O6001 ONCOLOGY O6002 RADI ATI ON ONCOLOGY	0	950, 340		1, 787, 858	0	
65. 00	06500 RESPIRATORY THERAPY	4, 593	1, 271, 381	1	2, 530, 678	_	1
66. 00	06600 PHYSI CAL THERAPY	881	1, 427, 045	1	2, 491, 312		1
69. 00	06900 ELECTROCARDI OLOGY	8, 071	713, 687	r c	1, 267, 487		
69. 01	06901 CARDI AC REHAB	1, 297	112, 249	1	213, 482		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		_	0	
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	
73.00	OUTPATIENT SERVICE COST CENTERS	1 0		ή	0, 371, 733		73.00
90.00	09000 CLI NI C	2, 832	197, 050) C	474, 767	2, 832	90.00
	09100 EMERGENCY	11, 086	3, 655, 348	S C	6, 086, 496	11, 086	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	O9201 OBSERVATI ON BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0) C	0	0	92. 01
95. 00	09500 AMBULANCE SERVICES	4, 153	851, 939	C	1, 350, 076	4, 153	95. 00
	SPECIAL PURPOSE COST CENTERS	., ., .,	22.7.22		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,	1
	11300 I NTEREST EXPENSE						113. 00
118.00		367, 060	42, 142, 541	-20, 976, 617	90, 886, 337	294, 477	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 347	19, 838	S C	81, 706	1 347	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 347	17, 030	1			192. 00
	19202 VI SI TOR MEALS	0	0	Ö			192. 02
192. 03	19203 GREAT BEGINNINGS/MATERNAL	0	129, 184	· c	176, 282		192. 03
	19204 LI FELI NE	0	0	0			192. 04
	19205 OWNED PROPERTIES	0	20.020		,		192. 05 192. 08
	19211 PARISH NURSING 19212 BIOTERRORISM GRANT	342	38, 820 19, 480	1	87, 940 51, 516		192. 08
	19214 BREAST PUMPS	6	1, 172	1	,		192. 10
	19210 MGH PHYS PRACT MGMT	0	1, 042, 915	1		0	192. 14
	19215 MGH MARION SURGEONS	0	336, 376		-,,		192. 15
	19216 MGH MGH MED ONC	0	0	1			192. 16
192. 17	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	0	604, 848 125, 386		2, 368, 228 556, 811	l .	192. 17 192. 18
	19219 MGH FMC MARION		254, 426	•			192. 10
	19300 NONPALD WORKERS		0) c	0	0	193. 00
193. 01	19301 MGH FMC NORTHWOOD	0	201, 819		,	l .	193. 01
	19302 MGH FMC GAS CITY	0	179, 200		,		193. 02
	19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	0	32, 189 690, 788				193. 03 193. 04
193.04	117304 WUT WAK FAW FKACI	1 0	090, 788	וי	2, 327, 781		1173. 04

Provider CCN: 150011

			To	06/30/2014	Date/Time Pre 11/20/2014 2:	
	CAPI TAL				1172072014 2.	40 piii
	RELATED COSTS					
Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation			
	FLXT	BENEFITS		& GENERAL	REPAI RS	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
	FEET)	(GROSS		COST)	FEET)	
		SALARI ES)				
	1.00	4. 00	5A	5. 00	6. 00	
193. 05 19305 MGH FMC SWAYZEE	0	49, 130		167, 551		193. 05
193. 06 19306 MGH PEDIATRIC CTR	0	204, 335		1, 059, 031		193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	80, 924		328, 557		193. 07
193.08 19308 MGH FMC CONVERSE	0	73, 542		253, 656	-	193. 08
193.09 19309 MGH UPLAND HEALTH	0	359, 574	0	1, 259, 495		193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0		193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	64, 681	0	521, 256		193. 11
193. 12 19312 OB/GYN	0	420, 888	0	2, 357, 617		193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
194.00 07963 OTHER NONREI MBURSABLE	0	0	0	0		194. 00
194. 01 07950 MOW	0	0	0	0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	0	0	0		194. 02
194. 03 07952 ADVERTI SI NG	0	189, 993	0	373, 432	0	194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	313, 924	0	841, 059	0	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	49, 430	0	168, 516	0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	258, 587	0	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	59, 878	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	11, 272	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	11, 206, 929	17, 034, 162		20, 976, 617	0	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	30. 391260	0. 357670)	0. 182833	0.000000	203. 00
204.00 Cost to be allocated (per Wkst. B,		394, 934		1, 872, 550	0	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 008293		0. 016321	0. 000000	205. 00
)						

	Financial Systems	MARION GENERA				u of Form CMS-:	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2013 o 06/30/2014	Worksheet B-1 Date/Time Pre	pared:
	Cost Center Description	CAFETERIA (MEALS SERVED)	CAFETERI A (HOURS WORKED)	OPERATION OF PLANT (SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVICE)	46 pm
		6. 01	6. 02	7. 00	LAUNDRY) 8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00 5. 00 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00601 CAFETERIA 00602 CAFETERIA 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	201, 682 186, 363 0 0 0 0 0 0	1, 398, 255 28, 556 0 0 23, 629 14, 537 56, 838	195, 973 2, 114 3, 342 6, 786 700 2, 384	685, 505 0 26, 215 0 10, 285	57, 668 832 260 1, 300 832	10. 00 13. 00 14. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		050 554	14.040	007.005	10.0(4	
30. 00 31. 00 40. 00 41. 00 42. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0 0 0 0 0	358, 551 86, 605 0 40, 523 0	44, 013 10, 010 0 9, 548 0	43, 095 0 22, 163 0	12, 064 3, 328 0 2, 912 0	31. 00 40. 00 41. 00 42. 00
50.00	05000 OPERATING ROOM	0	118, 866	35, 079	119, 439	8, 528	
51. 00 54. 00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	0 89, 262	0 21, 644		2 600	
54.00	05700 CT SCAN	0	17, 276		12, 931	2, 600 156	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	9, 879	4, 444	163	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	22, 198			1, 040	
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY	0	108, 396 0	11, 685 0		2, 912 0	1
60. 02	06002 RADIATION ONCOLOGY	0	0	Ö	0, 100	0	1
65. 00	06500 RESPI RATORY THERAPY	0	39, 702			2, 184	
66.00	06600 PHYSI CAL THERAPY	0	24, 390			1 404	
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	31, 130 4, 603			1, 404 1, 560	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	_	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
90. 00	09000 CLINIC	0	6, 738	2, 832	4, 312	1, 040	90.00
91.00	09100 EMERGENCY	0	144, 128			11, 648	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_		_	_	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92. 01
95. 00	09500 AMBULANCE SERVICES	0	48, 430	4, 153	29, 753	364	95. 00
	SPECIAL PURPOSE COST CENTERS			·			
	11300 INTEREST EXPENSE	10/ 0/0	4 074 007	404 070	(04.440	E4 0/4	113.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	186, 363	1, 274, 237	194, 278	681, 113	54, 964	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	728	1, 347	0	104	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	_		192.00
	19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL	15, 319	0	0	0		192. 02 192. 03
	19204 LI FELI NE	0	0	Ö	o		192. 04
	19205 OWNED PROPERTIES	0	0	0	0		192. 05
	19211 PARISH NURSING 19212 BIOTERRORISM GRANT	0	1, 363	342	l .		192. 08 192. 09
	19214 BREAST PUMPS		21	6	-		192. 10
	19210 MGH PHYS PRACT MGMT	0	54, 444				192. 14
	19215 MGH MARI ON SURGEONS	0	18, 655		0		192. 15
	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	0	0	0	_		192. 16 192. 17
	19218 MGH FAIRM MED ASSOC	0	0	Ö		0	192. 18
	19219 MGH FMC MARION	0	17, 724	0	750		192. 19
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY		0	0	0 481		193. 01 193. 02
193. 03	19303 MGH HOSPI TALI STS		0	Ö		0	193. 03
	19304 MGH MAR FAM PRACT	0	0	0	847		193. 04
	19305 MGH FMC SWAYZEE 19306 MGH PEDIATRIC CTR	0	0 14, 141	0	0 470		193. 05 193. 06
	19307 MGH SPECIALTY PHYS	0	5, 110				193. 07
		,			'		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

			T	o 06/30/2014	Date/Time Pre	
					11/20/2014 2:	46 pm
Cost Center Description	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	(MEALS SERVED)	(HOURS	PLANT	LINEN SERVICE	(HOURS OF	
		WORKED)	(SQUARE	(POUNDS OF	SERVI CE)	
			FEET)	LAUNDRY)		
	6. 01	6. 02	7. 00	8. 00	9. 00	
193.08 19308 MGH FMC CONVERSE	0	0	0	124		193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	0	969		193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0		193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	4, 545	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	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	194. 00
194. 01 07950 MOW	0	0	0	0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	0	0	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	7, 287	0	0	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	o	0	0	640	0	194. 04
194. 05 07954 MGH TAYLOR UNIVERSITY	O	0	0	0	0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194. 08
194. 09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	194. 09
194. 10 07959 MGH 106 LYONS BLDG	o	0	0	0	0	194. 10
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 629, 190	1, 505, 443	8, 584, 986	615, 025		
Part I)	", "=", "	.,				
203.00 Unit cost multiplier (Wkst. B, Part I)	8. 078014	1. 076658	43, 806984	0. 897185	54, 229694	203. 00
204.00 Cost to be allocated (per Wkst. B,	169, 634	156, 749				
Part II)	107,001	100/ / 1/	0,020,07.	101,000	171,200	2011.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 841096	0. 112103	15, 426074	0. 151809	3. 368471	205 00
		27.1.2.00		21.101007		
1 1	1		1	1		1

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150011 Po	eri od:	Worksheet B-1
				rom 07/01/2013 0 06/30/2014	Date/Time Prepared:
Cost Center Description	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	11/20/2014 2: 46 pm
	10.00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS					
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS 6. 01 00601 CAFETERIA 6. 02 00602 CAFETERIA 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY	91, 454				1. 00 4. 00 5. 00 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	0	1, 297, 683			13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	1, 005	1 000	14.00
15. 00 O1500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	56, 838	0	1, 000	15. 00
30. 00 03000 ADULTS & PEDIATRICS	55, 065	358, 551	193	0	30.00
31.00 03100 INTENSIVE CARE UNIT	9, 157	86, 605	100	o	31.00
40. 00 04000 SUBPROVI DER - 1 PF	0 220		0	0	40.00
41. 00 04100 SUBPROVI DER - 1 RF 42. 00 04200 SUBPROVI DER	8, 228		0	0	41. 00 42. 00
43. 00 04300 NURSERY	Ö		0	o	43.00
ANCILLARY SERVICE COST CENTERS	1				
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0		338 0	0	50. 00 51. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		1	10	0	54.00
57. 00 05700 CT SCAN	0		0	o	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	22, 198 127, 557	0 50	0	59. 00 60. 00
60. 01 06001 0NCOLOGY		38, 365	3	o	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	O	0	o	60. 02
65. 00 06500 RESPI RATORY THERAPY	0	46, 784	40	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0	44, 867 31, 130	4	0	66. 00 69. 00
69. 01 06901 CARDI AC REHAB	0	4, 603	0	o	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	_	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	_	0	1, 000	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	1, 000	75.00
90. 00 09000 CLI NI C	0	-,	0	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 009	144, 128	100	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS		-			
95. 00 09500 AMBULANCE SERVI CES	0	48, 430	0	0	95. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	73, 459	1, 292, 600	838	1, 000	118. 00
NONREI MBURSABLE COST CENTERS	1			-1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	_	0	0	190. 00 192. 00
192. 02 19202 VI SI TOR MEALS		0	0	0	192. 02
192. 03 19203 GREAT BEGINNI NGS/MATERNAL	0	5, 062	0	O	192. 03
192. 04 19204 LI FELI NE	0	0	0	0	192. 04
192. 05 19205 OWNED PROPERTIES 192. 08 19211 PARISH NURSING	0		0	0	192. 05 192. 08
192. 09 19212 BI OTERRORI SM GRANT	0	Ö	0	o	192. 09
192.10 19214 BREAST PUMPS	0	21	0	o	192. 10
192.14 19210 MGH PHYS PRACT MGMT 192.15 19215 MGH MARION SURGEONS	0	0	0 30	0	192. 14 192. 15
192. 15 19215 MGH MARTON SURGEONS 192. 16 19216 MGH MGH MED ONC			0	0	192. 15
192. 17 19217 MGH FMC SOUTH	0	O	2	0	192. 17
192. 18 19218 MGH FAI RM MED ASSOC	0	0	0	0	192. 18
192. 19 19219 MGH FMC MARION 193. 00 19300 NONPALD WORKERS	0	0	10 0	0	192. 19 193. 00
193. 01 19301 MGH FMC NORTHWOOD			10	ol	193. 00
193.02 19302 MGH FMC GAS CITY	0	o	10	o	193. 02
193. 03 19303 MGH HOSPI TALI STS	0	0	0	0	193. 03
193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE			30 10	0	193. 04 193. 05
193. 06 19306 MGH PEDIATRIC CTR	0	_	10		193. 06
		·		<u> </u>	·

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1
				From 07/01/2013	D 1 (T)
				Го 06/30/2014	Date/Time Prepared: 11/20/2014 2:46 pm
Cost Center Description	DI ETARY	NURSI NG	CENTRAL	PHARMACY	1172072014 2. 40 pili
cost center bescription		ADMI NI STRATI ON	SERVICES &	(COSTED	
	SERVED)	, town it or it the or	SUPPLY	REQUIS.)	
	0225)	(DI RECT	(COSTED	112451517	
		NRSING HRS)	REQUIS.)		
	10.00	13.00	14. 00	15. 00	
193. 07 19307 MGH SPECIALTY PHYS	0	0		0	193. 07
193.08 19308 MGH FMC CONVERSE	0	0		5 0	193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	4	0	193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0	193. 11
193. 12 19312 OB/GYN	0	0	!	5 0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	(0	193. 15
194. 00 07963 OTHER NONREIMBURSABLE	0	0	(0	194. 00
194. 01 07950 MOW	12, 169	0	(0	194. 01
194. 02 07951 MENTAL HEALTH	5, 826	0	(0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	(0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0		5 0	194. 04
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0	(0	194. 05
194.08 07957 MGH SMMP BLDG	0	0	(0	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	(0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	(0	194. 10
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 312, 427	1, 481, 619	1, 253, 49	4, 615, 912	202. 00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 350679				203. 00
204.00 Cost to be allocated (per Wkst. B,	330, 759	62, 054	133, 29	1 230, 306	204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	3. 616671	0. 047819	132. 62786	1 230. 306000	205. 00
1)					I

Date/Time Prepared: 06/30/2014 11/20/2014 2:46 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 20, 331, 265 20, 331, 265 20, 331, 265 03100 INTENSIVE CARE UNIT 5, 869, 504 5, 869, 504 0 5, 869, 504 31.00 31.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 04100 SUBPROVI DER - I RF 0 3, 531, 584 41.00 3, 531, 584 41.00 3, 531, 584 04200 SUBPROVI DER 0 42.00 \cap 0 42.00 43.00 04300 NURSERY 1, 649, 780 1, 649, 780 1, 649, 780 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 14, 660, 607 14, 660, 607 0 14, 660, 607 51.00 05100 RECOVERY ROOM 0 Ω 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 114, 949 8, 114, 949 0 0 0 8, 114, 949 54.00 57.00 05700 CT SCAN 1, 332, 317 1, 332, 317 1, 332, 317 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,048,763 1,048,763 1, 048, 763 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 541, 170 4, 541, 170 4, 541, 170 59.00 06000 LABORATORY 10, 629, 904 10, 629, 904 10, 629, 904 60.00 0 0 0 0 0 60.00 06001 ONCOLOGY 2, 169, 608 60 01 2, 169, 608 2, 169, 608 60 01 60.02 06002 RADIATION ONCOLOGY Ω 60.02 65.00 06500 RESPIRATORY THERAPY 3, 467, 391 3, 467, 391 3, 467, 391 65.00 66.00 06600 PHYSI CAL THERAPY 3,080,239 3, 080, 239 3, 080, 239 66.00 06900 ELECTROCARDI OLOGY 2,008,114 2, 008, 114 2, 008, 114 69 00 69 00 69.01 06901 CARDI AC REHAB 404, 198 404, 198 404, 198 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 71.00 o 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 12, 152, 845 12, 152, 845 0 12, 152, 845 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 760, 847 0 760, 847 90.00 760, 847 09100 EMERGENCY o 91 00 8, 863, 145 8, 863, 145 8, 863, 145 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 3, 943, 980 3, 943, 980 3, 943, 980 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 932, 716 1, 932, 716 1, 932, 716 95.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 110, 492, 926 0 110, 492, 926 0 110, 492, 926 200. 00

3, 943, 980

106, 548, 946

3, 943, 980

106, 548, 946

3, 943, 980 201. 00

106, 548, 946 202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 11/20/2014 2:46 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 18, 868, 616 18, 868, 616 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 852, 764 7, 852, 764 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 3, 641, 022 3, 641, 022 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 2, 438, 736 2, 438, 736 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 05000 OPERATING ROOM 50, 195, 472 0.166767 50.00 37, 715, 310 87, 910, 782 05100 RECOVERY ROOM 51.00 0.000000 0.000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 714, 757 20, 586, 904 22, 301, 661 0.363872 0.000000 54.00 57.00 05700 CT SCAN 3, 184, 685 24, 991, 355 28, 176, 040 0.047285 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 779, 681 365, 505 4, 145, 186 0.253007 0.000000 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 2,600,692 7, 049, 816 9, 650, 508 0.470563 0.000000 59.00 06000 LABORATORY 5, 705, 073 19, 592, 869 25, 297, 942 0. 420188 0.000000 60.00 60.00 60.01 06001 ONCOLOGY 35, 232 6, 108, 573 6, 143, 805 0. 353138 0.000000 60.01 06002 RADIATION ONCOLOGY 0.000000 0.000000 60.02 60.02 65.00 06500 RESPIRATORY THERAPY 1, 283, 869 5, 263, 184 6, 547, 053 0.529611 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 128, 944 7, 488, 038 12, 616, 982 0. 244134 0.000000 66.00 66.00 06900 ELECTROCARDI OLOGY 3, 058, 833 5, 366, 894 8, 425, 727 0.238331 0.000000 69.00 69.00 06901 CARDI AC REHAB 69.01 320 714, 028 714, 348 0.565828 0.000000 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0.000000 72.00 6, 929, 849 73 00 07300 DRUGS CHARGED TO PATIENTS 41, 635, 495 48, 565, 344 0.250237 0.000000 73 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3. 161383 0.000000 90.00 240, 669 240, 669 91.00 09100 EMERGENCY 7, 015, 437 46, 973, 289 53, 988, 726 0.164167 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.531627 92.00 92.00 0 7, 418, 693 7, 418, 693 0.000000 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 4, 003, 870 4, 003, 870 0. 482712 0.000000 95 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00

107, 539, 644

107, 539, 644

251, 408, 830

251, 408, 830

358, 948, 474

358, 948, 474

200.00

201. 00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

Period:
From 07/01/2013
To 06/30/2014
Date/Time Prepared:

			10 06/30/2014	Date/II me Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - I PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41. 00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 166767			50. 00
51.00 05100 RECOVERY ROOM	0. 000000			51. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 363872			54. 00
57. 00 05700 CT SCAN	0. 047285			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 253007			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 470563			59. 00
60. 00 06000 LABORATORY	0. 420188			60. 00
60. 01 06001 ONCOLOGY	0. 353138			60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000			60. 02
65. 00 06500 RESPI RATORY THERAPY	0. 529611			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 244134			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 238331			69. 00
69. 01 06901 CARDI AC REHAB	0. 565828			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 250237			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	3. 161383			90. 00
91. 00 09100 EMERGENCY	0. 164167			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 531627			92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	0. 482712			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

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Period: Worksheet C From 07/01/2013 Part I			

To 06/30/2014 Date/Ti	2014 2:46 pm
Title XIX Hospital	Cost
Costs	
Cost Center Description Total Cost Therapy Limit Total Costs RCE Total	Costs
(from Wkst. B, Adj. Disallowance	
Part I, col.	
26)	
1.00 2.00 3.00 4.00 5.0	0
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 20, 331, 265 20, 331, 265 0 20, 3	31, 265 30. 00
	869, 504 31. 00
40. 00 04000 SUBPROVI DER - I PF 0 0 0	0 40.00
	31, 584 41. 00
42. 00 04200 SUBPROVI DER 0 0 0	0 42.00
	49, 780 43. 00
ANCILLARY SERVICE COST CENTERS	17, 700
	60, 607 50. 00
51. 00 05100 RECOVERY ROOM 0 0 0	0 51.00
	14, 949 54. 00
	32, 317 57. 00
	148, 763 58. 00
	341, 170 59. 00
	29, 904 60. 00
	69, 608 60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0 60.02
	67, 391 65. 00
	180, 239 66. 00
	04, 198 69. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0	0 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	0 72.00
	52, 845 73. 00
OUTPATIENT SERVICE COST CENTERS	
	60, 847 90. 00
	863, 145 91. 00
	943, 980 92. 00
92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0	0 92.01
OTHER REIMBURSABLE COST CENTERS	
	95. 00
SPECIAL PURPOSE COST CENTERS	
113.00 11300 I NTEREST EXPENSE	113. 00
	92, 926 200. 00
	43, 980 201. 00
202.00 Total (see instructions) 106,548,946 0 106,548,946 0 106,548,946	48, 946 202. 00

From 07/01/2013 Part I Date/Time Prepared: 06/30/2014 11/20/2014 2:46 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 18, 868, 616 18, 868, 616 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 852, 764 7, 852, 764 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 3.641.022 3, 641, 022 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 2, 438, 736 2, 438, 736 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 05000 OPERATING ROOM 50, 195, 472 0.166767 50.00 37, 715, 310 87, 910, 782 05100 RECOVERY ROOM 51.00 0.000000 0.000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 714, 757 20, 586, 904 22, 301, 661 0.363872 0.000000 54.00 57.00 05700 CT SCAN 3, 184, 685 24, 991, 355 28, 176, 040 0.047285 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 779, 681 365, 505 4, 145, 186 0.253007 0.000000 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 2,600,692 7, 049, 816 9, 650, 508 0.470563 0.000000 59.00 06000 LABORATORY 5, 705, 073 19, 592, 869 25, 297, 942 0. 420188 0.000000 60.00 60.00 60.01 06001 ONCOLOGY 35, 232 6, 108, 573 6, 143, 805 0. 353138 0.000000 60.01 06002 RADIATION ONCOLOGY 0.000000 0.000000 60.02 60.02 65.00 06500 RESPIRATORY THERAPY 1, 283, 869 5, 263, 184 6, 547, 053 0.529611 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 128, 944 7, 488, 038 12, 616, 982 0. 244134 0.000000 66.00 66.00 06900 ELECTROCARDI OLOGY 3, 058, 833 5, 366, 894 8, 425, 727 0.238331 0.000000 69.00 69.00 06901 CARDI AC REHAB 69.01 320 714, 028 714, 348 0.565828 0.000000 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0.000000 72.00 6, 929, 849 73 00 07300 DRUGS CHARGED TO PATIENTS 41, 635, 495 48, 565, 344 0.250237 0.000000 73 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3. 161383 0.000000 90.00 240, 669 240, 669 91.00 09100 EMERGENCY 7, 015, 437 46, 973, 289 53, 988, 726 0.164167 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.531627 92.00 92.00 0 7, 418, 693 7, 418, 693 0.000000 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 4, 003, 870 4, 003, 870 0. 482712 0.000000 95 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 107, 539, 644 251, 408, 830 358, 948, 474 200.00

107, 539, 644

251, 408, 830

358, 948, 474

201. 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150011	Peri od: Worksheet C From 07/01/2013 Part I To 06/30/2014 Date/Time Prepared:

				10 06/30/2014	11/20/2014 2: 4	
			Title XIX	Hospi tal	Cost	<u> </u>
Cost Cent	er Description	PPS Inpatient		· · · · · ·		
		Ratio				
		11. 00				
	NE SERVICE COST CENTERS					
30. 00 03000 ADULTS &						30.00
31. 00 03100 I NTENSI VE						31.00
40. 00 04000 SUBPROVI D						40.00
41. 00 04100 SUBPROVI D						41.00
42. 00 04200 SUBPROVI D	ER					42.00
43. 00 04300 NURSERY						43.00
	CE COST CENTERS					
50. 00 05000 OPERATI NG		0. 000000				50.00
51. 00 05100 RECOVERY		0. 000000				51.00
54. 00 05400 RADI OLOGY	-DI AGNOSTI C	0. 000000				54.00
57.00 05700 CT SCAN		0. 000000				57.00
	RESONANCE IMAGING (MRI)	0. 000000				58.00
59. 00 05900 CARDI AC C		0. 000000				59.00
60. 00 06000 LABORATOR	Y	0. 000000				60.00
60. 01 06001 ONCOLOGY		0. 000000				60. 01
60. 02 06002 RADI ATI ON		0. 000000				60. 02
65. 00 06500 RESPI RATO		0. 000000				65.00
66. 00 06600 PHYSI CAL		0. 000000				66.00
69. 00 06900 ELECTROCA		0. 000000				69.00
69. 01 06901 CARDI AC R		0. 000000				69. 01
	UPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 I MPL. DEV		0. 000000				72.00
	RGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERV	ICE COST CENTERS					
90. 00 09000 CLI NI C		0. 000000				90.00
91. 00 09100 EMERGENCY		0. 000000				91.00
	ON BEDS (NON-DISTINCT PART)	0. 000000				92.00
	ON BEDS (DISTINCT PART)	0. 000000				92. 01
	BLE COST CENTERS					
95. 00 09500 AMBULANCE		0. 000000				95.00
SPECIAL PURPOSE		,				
113. 00 11300 I NTEREST						113. 00
	(see instructions)					200. 00
	rvation Beds					201. 00
202.00 Total (se	e instructions)				:	202. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150011	Period: From 07/01/2013 To 06/30/2014		pared:
		Ti tl	e XVIII	Hospi tal	PPS	40 piii
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	,	Related Cost		Í	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 655, 043	0	2, 655, 04	3 18, 424	144. 11	30.00
31.00 INTENSIVE CARE UNIT	623, 117		623, 11	7 3, 817	163. 25	31. 00
40. 00 SUBPROVI DER - I PF	0	0)	0 0	0.00	40. 00
41. 00 SUBPROVI DER - I RF	532, 735	0	532, 73	5 2, 854	186. 66	41. 00
42. 00 SUBPROVI DER	0	0)	0 0	0.00	
43. 00 NURSERY	30, 362		30, 36	2, 209	13. 74	43.00
200.00 Total (lines 30-199)	3, 841, 257		3, 841, 25	7 27, 304		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	7, 139					30.00
31.00 INTENSIVE CARE UNIT	1, 830		1			31. 00
40. 00 SUBPROVI DER - I PF	0	0				40. 00
41. 00 SUBPROVI DER - I RF	2, 166		1			41.00
42. 00 SUBPROVI DER	0	0	1			42. 00
43. 00 NURSERY	0	0	1			43.00
200.00 Total (lines 30-199)	11, 135	1, 731, 855	1			200. 00

Health Financial Systems	ems MARION GENERAL HOSPITAL				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE C.	APITAL COSTS		Provi der		Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Pre 11/20/2014 2:4	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total	l Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from	wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part	I, col.	(col . 1 ÷ col	. Charges	column 4)	

					11/20/2014 2.4	40 piii
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 907, 393	87, 910, 782	0. 021697	13, 957, 643	302, 839	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 137, 285	22, 301, 661		1, 010, 560	51, 535	54.00
57.00 05700 CT SCAN	95, 168	28, 176, 040	0. 003378	1, 889, 711	6, 383	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	218, 738	4, 145, 186	0. 052769	193, 903	10, 232	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	302, 039	9, 650, 508	0. 031298	1, 217, 697	38, 111	59. 00
60. 00 06000 LABORATORY	723, 973	25, 297, 942	0. 028618	2, 986, 547	85, 469	60. 00
60. 01 06001 0NCOLOGY	40, 534	6, 143, 805	0. 006598	17, 678	117	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0	0.000000	0	0	60. 02
65. 00 06500 RESPIRATORY THERAPY	283, 045	6, 547, 053	0. 043232	638, 765	27, 615	65. 00
66. 00 06600 PHYSI CAL THERAPY	100, 675	12, 616, 982	0. 007979	1, 470, 444	11, 733	66. 00
69. 00 06900 ELECTROCARDI OLOGY	407, 506	8, 425, 727	0. 048364	1, 895, 493	91, 674	69. 00
69. 01 06901 CARDI AC REHAB	69, 841	714, 348	0. 097769	320	31	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	334, 302	48, 565, 344	0. 006884	3, 350, 628	23, 066	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	144, 373	240, 669	0. 599882	0	0	90.00
91. 00 09100 EMERGENCY	731, 600	53, 988, 726	0. 013551	3, 238, 145	43, 880	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	515, 040	7, 418, 693	0. 069425	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	•					
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	7, 011, 512	322, 143, 466		31, 867, 534	692, 685	200. 00
	•	•				•

Heal th Financial Systems	MARI ON GENERA		00N 450044 B		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	IS Provider	F	eriod: from 07/01/2013 fo 06/30/2014	Worksheet D Part III Date/Time Pre 11/20/2014 2:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cost		1 through 3,	
					minus col. 4)	
LAUDATI ENT. DOUTLINE OFFICE OF COOT OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				ا		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	0	-	1	0	
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	0	0			0	
41. 00 04100 SUBPROVI DER - 1 PF	0	0			0	
42. 00 04200 SUBPROVI DER	0	0			0	
43. 00 04300 NURSERY	0	0			0	
200. 00 Total (lines 30-199)	0	0	l o		_	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpatient	Inpatient	PSA Adj.	200.00
μ	Days	5 ÷ col. 6)	Program Days		Nursing School	
		,		Pass-Through	Ü	
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00	11. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10.404	0.00	7 400	ا	0	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	18, 424	0.00	,		0	
	3, 817	0.00	,		0	
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF	2, 854	0. 00 0. 00	l .		0	
42. 00 04200 SUBPROVI DER - 1 RF	2, 654	0.00		1	0	
43. 00 04300 NURSERY	2, 209		1	-	0	
200.00 Total (lines 30-199)	27, 304	0.00	11, 135	-		200.00
Cost Center Description	PSA Adj.	PSA Adj. All	11, 100	<u> </u>		200.00
	Allied Health					
	Cost	Education Cost				
	12. 00	13. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1			30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0				31.00
40. 00 04000 SUBPROVI DER - PF	0	0	1			40.00
41. 00 04100 SUBPROVI DER - I RF	0	0				41.00
10.00 0.100 0.1000 0.50						42.00
42. 00 04200 SUBPROVI DER	0	0				
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY 200. 00 Total (Lines 30-199)	0	0				43. 00

Heal th	Financial Systems	MARION GENER	ΔΙ ΗΩΩΡΙΤΔΙ		In lie	eu of Form CMS-:	2552_10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV	pared:
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	(0	0	50.00
51.00	05100 RECOVERY ROOM	0	(0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0	0	54.00
57. 00	05700 CT SCAN	0	(0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	(0	0	59. 00
60. 00	06000 LABORATORY	0	(0	0	60.00
60. 01	06001 ONCOLOGY	0	C		0	0	60. 01
60. 02	06002 RADI ATI ON ONCOLOGY	0	(0	0	60. 02
65. 00	06500 RESPI RATORY THERAPY	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	(0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(0	0	69. 00
69. 01	06901 CARDI AC REHAB	0	(0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1 0)	0 0	0	73. 00

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0 90.00

0

0 0 92.01 95.00

91. 00 92. 00

0 200. 00

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

	Financial Systems	MARION GENERA					u of Form CMS-2	<u> 2552-10</u>
APPOR1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Pro	ovi der		Peri od:	Worksheet D	
THROUG	SH COSTS					From 07/01/2013		
						To 06/30/2014	Date/Time Prep 11/20/2014 2:	parea:
-				Ti +I	e XVIII	Hospi tal	PPS	40 piii
	Cost Center Description	Total	Total Ch		Ratio of Cost		Inpati ent	
	cost center bescription	Outpati ent	(from Wk			Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)		7)	(col . 6 ÷ col .	l charges	
		4)			')	7)		
		6, 00	7. 0	10	8, 00	9, 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00			0.00	7. 00		
50.00	05000 OPERATING ROOM	0	87. 9	10, 782	0.00000	0. 000000	13, 957, 643	50.00
51. 00	05100 RECOVERY ROOM	0		0	0.00000	0. 000000		51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	22.3	01, 661	0.00000	0. 000000	1, 010, 560	54.00
57. 00	05700 CT SCAN	0		76, 040				57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		45, 186				
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		50, 508		0. 000000	1, 217, 697	59.00
60.00	06000 LABORATORY	0		97, 942				60.00
60. 01	06001 ONCOLOGY	0		43, 805		0. 000000		
60. 02	06002 RADIATION ONCOLOGY	0		0	0.00000			60. 02
65. 00	06500 RESPIRATORY THERAPY	0	6.5	47, 053				65.00
66. 00	06600 PHYSI CAL THERAPY	0		16, 982		0. 000000	1, 470, 444	66, 00
69. 00	06900 ELECTROCARDI OLOGY	0		25, 727		0. 000000	1, 895, 493	69.00
69. 01	06901 CARDI AC REHAB	0	7	14, 348	0. 00000	0. 000000	320	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	i	. 0	0.00000	0. 000000	o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	i	0	0.00000	0. 000000	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	48.5	65, 344				73. 00
	OUTPATIENT SERVICE COST CENTERS						.,,	1
90.00	09000 CLI NI C	0	2	40, 669	0.00000	0. 000000	0	90.00
		1 _	l		1		(' '	l

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240, 669 53, 988, 726

7, 418, 693

322, 143, 466

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0. 000000 0. 000000 0. 000000

91. 00

92.00 0

0 92.01 95.00

31, 867, 534 200. 00

3, 238, 145

90. 00 | 09000 CLINIC
91. 00 | 09100 | EMERGENCY
92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART)
92. 01 | 09201 | 0BSERVATION BEDS (DISTINCT PART)
0THER REIMBURSABLE COST CENTERS
95. 00 | 09500 | AMBULANCE SERVICES
200. 00 | Total (lines 50-199)

Health Financial Systems	MARION GENER	AL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	CILLARY SERVICE OTHER PAS	S	Provi der	CCN: 150011	From 07/01/2013	Worksheet D Part IV Date/Time Pre 11/20/2014 2:	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	0u	tpati ent	Outpati ent	PSA Adj . Non	PSA Adj.	

			Т	o 06/30/2014	Date/Time Pre 11/20/2014 2:	pared: 46 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
	Program	Program	Program		Nursing School	
	Pass-Through	Charges	Pass-Through	Anesthetist		
	Costs (col. 8		Costs (col. 9	Cost		
	x col. 10)		x col. 12)			
	11. 00	12. 00	13.00	21. 00	22. 00	
ANCI LLARY SERVI CE COST CENTERS	T			T		
50. 00 05000 OPERATI NG ROOM	0	12, 569, 942	2 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	5, 791, 760	1	0	0	54. 00
57. 00 05700 CT SCAN	0	7, 508, 287		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 221, 634		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	3, 513, 830	1	0	0	59. 00
60. 00 06000 LABORATORY	0	2, 293, 184	1	0	0	60.00
60. 01 06001 0NCOLOGY	0	2, 911, 664	∤	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	1, 625, 930		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	26		0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 879, 811	1	0	0	69. 00
69. 01 06901 CARDI AC REHAB	0	304, 000	0	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) C	0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	18, 664, 056	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	98, 157	1	0	0	
91. 00 09100 EMERGENCY	0	9, 724, 845	5 C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 503, 637	' C	0	0	92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0) C	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	,			1		1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	69, 610, 763	3 C	0	0	200. 00

Health Financial	Systems		MAR	RION GENERA	L HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER PASS	,	Provi der CCN: 150011	Peri od: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/20/2014 2:46 pm

					11/20/2014 2: 46 pm
		Ti tl	e XVIII	Hospi tal	PPS
Cost Center Description	PSA Adj . PS	SA Adj. All			
	Allied Health Ot	her Medical			
	Edu	ucation Cost			
	23. 00	24.00			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0			50.00
51.00 05100 RECOVERY ROOM	0	0			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
57. 00 05700 CT SCAN	0	0			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			59. 00
60. 00 06000 LABORATORY	0	0			60.00
60. 01 06001 0NCOLOGY	0	0			60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0			60. 02
65. 00 06500 RESPIRATORY THERAPY	o	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0			66. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0			69.00
69. 01 06901 CARDI AC REHAB	o	0			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0			73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	0			90.00
91. 00 09100 EMERGENCY	0	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0			92. 01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95. 00
200.00 Total (lines 50-199)	0	0			200. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 07/01/2013 To 06/30/2014	Part V Date/Time Pre	nared:
				10 00/ 30/ 2014	11/20/2014 2:	
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00	2. 00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 166767	12, 569, 942		0	2, 096, 252	50.00
51. 00 05100 RECOVERY ROOM	0. 000000		•	0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 363872			0 0	2, 107, 459	54.00
57. 00 05700 CT SCAN	0. 047285			0	355, 029	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 253007			0 0	309, 082	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 470563			0 0	1, 653, 478	
60. 00 06000 LABORATORY	0. 420188			2 0	963, 568	
60. 01 06001 ONCOLOGY	0. 353138	2, 911, 664		0 0	1, 028, 219	60. 01
60. 02 06002 RADIATION ONCOLOGY	0. 000000	0		0 0	0	60. 02
65. 00 06500 RESPIRATORY THERAPY	0. 529611	1, 625, 930		0	861, 110	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 244134	26		0 0	6	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 238331	1, 879, 811		0 0	448, 017	69. 00
69. 01 06901 CARDI AC REHAB	0. 565828			0 0	172, 012	
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	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 250237	18, 664, 056		0 19, 107	4, 670, 437	73. 00
OUTPATIENT SERVICE COST CENTERS	T	1	ı	T		
90. 00 09000 CLI NI C	3. 161383			0	310, 312	90.00
91. 00 09100 EMERGENCY	0. 164167		•	0	1, 596, 499	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 531627		1	0	799, 374	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	0.400740	ı	I			05.00
95. 00 09500 AMBULANCE SERVI CES	0. 482712		1	0	47 070 054	95.00
200.00 Subtotal (see instructions)		69, 610, 763	9, 45	2 19, 107	17, 370, 854	
201.00 Less PBP Clinic Lab. Services-Program				이 이		201. 00
Only Charges 202.00 Net Charges (line 200 +/- line 201)		69, 610, 763	9, 45	2 19, 107	17, 370, 854	202 00
202.00 Net charges (Title 200 +/ - Title 201)	1	1 09,010,763	9, 45	Z 19, 107	17, 370, 854	1202.00

				10 06/30/2014	Date/lime Prep 11/20/2014 2:	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subj ect To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLILIADIA OFRIA OF COOT OFFITEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						F0 00
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57. 00 05700 CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	3, 972	0				60.00
60. 01 06001 0NCOLOGY	0	0				60. 01
60. 02 06002 RADI ATI ON ONCOLOGY 65. 00 06500 RESPI RATORY THERAPY	0	0				60. 02 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	0	4, 781				73.00
OUTPATIENT SERVICE COST CENTERS		4, 701	I.			73.00
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0				92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	3, 972	4, 781				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 972	4, 781				202. 00

Heal th	Financial Systems	MARION GENERA	AI HOSPITAI		In lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150011	Peri od:	Worksheet D	2002 10
			Component	t CCN: 15T011	From 07/01/2013 To 06/30/2014	Part II Date/Time Pre 11/20/2014 2:	pared: 46 pm
			Ti tl	e XVIII	Subprovi der – I RF	PPS	•
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	Г 00	
	ANOLILIADY CEDVICE COCT CENTEDS	1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 007 202	87, 910, 782	0. 0216	97 391	8	50.00
	05100 RECOVERY ROOM	1, 907, 393 0		1			51.00
51.00			1	0.0000		0	54.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	1, 137, 285				1, 661	
57. 00		95, 168				132 718	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	218, 738					58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	302, 039 723, 973					
				1			
60. 01 60. 02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	40, 534				2	60. 01 60. 02
		0		0.00000		-	
65. 00	06500 RESPIRATORY THERAPY	283, 045				1, 866	
66. 00 69. 00	06600 PHYSI CAL THERAPY	100, 675					
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	407, 506		1		1, 160	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 841	714, 348	0.09776		0	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0.0000		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	334, 302	48, 565, 344	1		·	
73.00	OUTPATIENT SERVICE COST CENTERS	334, 302	48, 505, 344	0.0068	34 252, 448	1, 738	73.00
90. 00	09000 CLINIC	144, 373	240, 669	0. 5998	32 0	0	90.00
91. 00	09100 EMERGENCY	731, 600		1		315	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	731,000		1		0	92.00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)		7,410,073	1		0	92.00
72.01	OTHER REIMBURSABLE COST CENTERS			0.0000	50, 0		/2.01
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00		6, 496, 472	322, 143, 466		2, 567, 419	27, 200	

ANCILLARY SERVICE COST CENTERS	Heal th	Financial Systems	MARION GENER	AL HOSPI	ΓAL			In Lie	u of Form CMS-2	2552-10
Component CCN: 15T011 To 06/30/2014 Date/Time Prepared: 11/20/2014 2: 46 pm PPS IRF PRS PPS PRS						CCN: 150011	Peri od			
Title XVIII Subprovider IRF PPS	THROUG	H COSTS								
Title XVIII Subprovider - IRF				Cor	nponent	CCN: 15T011	To 0	6/30/2014		
Non Physician Nursing School Allied Health All Other Medical (sum of col 1 Ancitative Cost Cost					T: +1	s VVIIII	Cubaa	aud dan		46 pm
Non Physician Anesthetist Cost					11 (1	e xviii			PPS	
Anesthetist Cost Cost Education Cost		Cost Center Description	Non Physician	Nursi na	School	Allied Healt			Total Cost	
ANCI LLARY SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , ,							(sum of col 1	
ANCILLARY SERVICE COST CENTERS			Cost				Educa	tion Cost	through col.	
ANCILLARY SERVICE COST CENTERS									4)	
50. 00 05000 OPERATING ROOM 0 0 0 0 0 0 0 0 0			1.00	2.0	0	3.00		4. 00	5. 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 55. 00 05700 CT SCAN 0 0 0 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 60. 01 06001 ONCOLOGY 0 0 0 0 0 60. 02 06002 RADI ATI ON ONCOLOGY 0 0 0 0 60. 02 06002 RADI ATI ON ONCOLOGY 0 0 0 0 60. 03 06500 RESPI RATORY THERAPY 0 0 0 0 0 60. 04 06000 ELECTROCARDI OLOGY 0 0 0 0 60. 05 06900 ELECTROCARDI OLOGY 0 0 0 0 60. 01 06901 CARDI AC REHAB 0 0 0 0 60. 01 06901 CARDI AC REHAB 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74. 00 07000 CLI NI C 0 0 0 0 75. 00 09100 ELERGENCY 0 0 0 0 76. 00 09100 ELERGENCY 0 0 0 0 77. 00 07000 OSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 01 OP200 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 75. 00 OP300 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 75. 00 OP300 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 75. 00 OP300 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 75. 00 OP300 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 75. 00 OP300 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 75. 00 OP300 OP300										
54. 00			0		0		0	0	_	
57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 60. 01 06001 ONCOLOGY 0 0 0 0 0 60. 02 06002 RADIATION ONCOLOGY 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 69. 00 06900 CARDIAC REHAB 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 74. 00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 75. 00 09000 CLIN IC 0 0 0 76. 00 09100 EMERGENCY 0 0 0 0 77. 00 09100 EMERGENCY 0 0 0 0 78. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 79. 00 07500 DRUGS CHARGED COST CENTERS 79. 00 09500 AMBULANCE SERVICES 95. 00			0)	0		0	0	0	
\$8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 59. 00 60. 00 06000 LABORATIORY 0 0 0 0 0 0 0 60. 00 60. 01 06001 ONCOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		0		0	0	0	
59. 00			0		0		0	0	0	
60. 00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0		0	0	0	
60. 01 06001 0NCOLOGY	59.00	05900 CARDI AC CATHETERI ZATI ON	0		0		0	0	0	59. 00
60. 02	60.00	06000 LABORATORY	0		0		0	0	0	60.00
65. 00	60. 01	06001 ONCOLOGY	0		0		0	0	0	60. 01
66. 00	60.02	06002 RADIATION ONCOLOGY	0		0		0	0	0	60. 02
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 0 0 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0000 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0000 OTHER REI MBURSABLE COST CENTERS	65.00	06500 RESPI RATORY THERAPY	0		0		0	0	0	65.00
69. 01	66.00	06600 PHYSI CAL THERAPY	0		0		0	0	0	66. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0		0		0	0	0	69. 00
72. 00	69. 01	06901 CARDI AC REHAB	0		0		0	0	0	69. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0	0	71.00
OUTPATIENT SERVICE COST CENTERS O	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0	0	0	72.00
90. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0		0		0	0	0	73.00
91. 00										
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90.00	09000 CLI NI C	0		0		0	0	0	90. 00
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 92. 01	91.00	09100 EMERGENCY	0		0		0	0	0	91.00
OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES 95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	0	0	92.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0		0		0	0	0	92. 01
200.00 Total (lines 50-199) 0 0 0 0 200.00	95.00	09500 AMBULANCE SERVI CES								95. 00
	200.00	Total (lines 50-199)	0		0		0	0	0	200. 00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS		Componen		From 07/01/2013 To 06/30/2014	Part IV Date/Time Pre 11/20/2014 2:	
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
	'	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.	J	
		4)	ĺ	<u> </u>	7)		
		6.00	7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	87, 910, 782	0.00000	0. 000000	391	50.00
51.00	05100 RECOVERY ROOM	0	l c	0. 00000	0. 000000	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 301, 661	0.00000	0. 000000	32, 570	54. 00
57.00	05700 CT SCAN	0	28, 176, 040	0. 00000	0. 000000	39, 031	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4, 145, 186	0.00000	0. 000000	13, 598	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	9, 650, 508	0.00000	0. 000000	78	59. 00
60.00	06000 LABORATORY	0	25, 297, 942	0. 00000	0. 000000	122, 764	60.00
60. 01	06001 ONCOLOGY	0	6, 143, 805	0.00000	0. 000000	240	60. 01
60.02	06002 RADIATION ONCOLOGY	0	C	0.00000	0. 000000	0	60. 02
65.00	06500 RESPI RATORY THERAPY	0	6, 547, 053	0.00000	0. 000000	43, 152	65.00
66.00	06600 PHYSI CAL THERAPY	0	12, 616, 982	0. 00000	0. 000000	2, 015, 898	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	8, 425, 727	0. 00000	0. 000000	23, 978	69. 00
69. 01	06901 CARDI AC REHAB	0	714, 348	0.00000	0. 000000	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0.00000	0. 000000	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0.00000	0. 000000	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	48, 565, 344	0.00000	0. 000000	252, 448	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	240, 669	0.00000	0. 000000	0	90. 00
91.00	09100 EMERGENCY	0	53, 988, 726	0.00000	0. 000000	23, 271	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7, 418, 693	0.00000	0. 000000	0	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	C	0.00000	0. 000000	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	0	322, 143, 466	o [2, 567, 419	200. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		Provi der	CCN: 150011 t CCN: 15T011	Peri od: From 07/01/2013	Worksheet D Part IV Date/Time Pre	pared:
		Ti tl	e XVIII	Subprovi der - I RF	11/20/2014 2: PPS	46 pm_
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. x col. 12)	PSA Adj. Non Physician Anesthetist	PSA Adj. Nursing School	
	11.00	12. 00	13. 00	21. 00	22. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1	0	0	50. 00
51.00 O5100 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 0NCOLOGY	0	0)	0	0	60. 01
60. 02 06002 RADIATION ONCOLOGY	0	0)	0	0	60. 02
65. 00 06500 RESPIRATORY THERAPY	0	0)	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
69. 01 06901 CARDI AC REHAB	0	0)	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0)	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0)	0 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	o	0		0 0	0	200. 00

Health Financial Systems	MARION GENERAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150011		Worksheet D
THROUGH COSTS		Component CCN: 15T011	From 07/01/2013 To 06/30/2014	
		Title XVIII	Subprovi der -	PPS

				IRF	
Cost Center Description	PSA Adj.	PSA Adj. All			
	Allied Health	Other Medical			
		Education Cost			
	23.00	24.00			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	C)		50.00
51.00 05100 RECOVERY ROOM	0	C)		51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)		54.00
57.00 05700 CT SCAN	0	C)		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C)		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C)		59. 00
60. 00 06000 LABORATORY	0	C)		60.00
60. 01 06001 0NC0L0GY	0	C)		60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	C)		60. 02
65. 00 06500 RESPIRATORY THERAPY	0	C			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C)		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C			69. 00
69. 01 06901 CARDI AC REHAB	0	C			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C			73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	C			90.00
91. 00 09100 EMERGENCY	0	C			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C)		92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	C			92. 01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (lines 50-199)	0	[c)		200. 00

Health Financial Systems	MARION GENERAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Peri od:	Worksheet D-1
			From 07/01/2013	
			To 06/30/2014	Date/Time Prepared:
				11/20/2014 2:46 pm
		Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	11/20/2014 2: PPS	46 pm
	Cost Center Description	THE XVIII	nospi tui		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			18, 424	1.00
2.00	Inpatient days (including private room days, excluding swing-be			18, 424	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	ivate room days,	0	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		14, 850	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
7.00	reporting period	days) through becomber	31 01 the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			7 400	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	7, 139	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi	ons)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (including privat	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea			_	
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
10.00	SWING BED ADJUSTMENT			<u> </u>	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0. 00	17. 00
10.00	reporting period	CI D I 04 C		0.00	40.00
18. 00	00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0. 00	18. 00	
19. 00	i Gi				19. 00
	reporting period	<u> </u>			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			20, 331, 265	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
24.00	7 x line 19)	or the cost reporti	ing period (inite		24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
27, 00	x line 20)				27 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 20, 331, 265	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	THE 21 IIII III 3 TTHE 20)		20, 331, 203	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	lino 20)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	111le 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00					34. 00
35.00					35.00
36. 00 37. 00					36. 00 37. 00
37.00	27 minus line 36)	u private room cost ar	Trefellula (TIME	20, 331, 265	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	,		1, 103. 52	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	•		7, 878, 029 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +			7, 878, 029	
	· · · · · · · · · · · · · · · · · · ·	•		•	

Heal th	Financial Systems MARIO	ON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST	511 OZ.11Z.10.12		CCN: 150011	Peri od:	Worksheet D-1	
					From 07/01/2013 To 06/30/2014	Date/Time Prep	nared:
					10 00/30/2014	11/20/2014 2: 4	
				e XVIII	Hospi tal	PPS	
	· ·	otal ent Costlin	Total natient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
	mpatr	0031111	battent bays	col . 2)		4)	
		. 00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT 5	, 869, 504	3, 817	1, 537.	73 1, 830	2, 814, 046	43. 00
44.00							44. 00
45. 00							45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
171.00	Cost Center Description						171.00
	Taranta and the same and the sa					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3 Total Program inpatient costs (sum of lines 41 thro			ne)		7, 187, 225 17, 879, 300	
49.00	PASS THROUGH COST ADJUSTMENTS	Jugii 40) (Set	e mstructro	115)		17, 679, 300	49.00
50.00		routine se	rvices (from	Wkst. D, sun	n of Parts I and	1, 327, 549	50. 00
E1 00	Describered and and able to Dragram innations	onoi I I omi i	oomilooo (fr	om Wko+ D. s	um of Dorsto II	402 405	F1 00
51. 00	Pass through costs applicable to Program inpatient and IV)	ancillary s	services (Tr	OM WKSt. D, S	sum or Parts II	692, 685	51. 00
52.00	Total Program excludable cost (sum of lines 50 and	51)				2, 020, 234	52. 00
53. 00		pital rela	ted, non-phy	sician anesth	netist, and	15, 859, 066	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	Program di scharges					0	54. 00
55.00							55. 00
56. 00 57. 00	,	t and targ	ot amount (1	ino E4 minus	lino E2)	0	56. 00 57. 00
58. 00	, , , ,	st and targe	et allourt (i	THE 50 III HUS	111le 55)	0	58. 00
59. 00		period end	di ng 1996, u	pdated and co	ompounded by the		59. 00
(0.00	market basket					0.00	(0.00
60. 00 61. 00					the amount by	0. 00 0	60. 00 61. 00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							01.00
	amount (line 56), otherwise enter zero (see instruc	ctions)					
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	62. 00 63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST							00.00
64. 00		ough Decembe	er 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after	r December	31 of the c	ost renortino	neriod (See	0	65. 00
00.00	instructions)(title XVIII only)	, December	01 01 110 0	ost roportring	, perred (occ	Ĭ	00.00
66. 00		s (line 64	plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs	through De	ecember 31 o	f the cost re	eporting period	0	67. 00
07.00	(line 12 x line 19)	, em ough b	00000		ppor tring por rod		07.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs	after Dece	ember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine	costs (li	ne 67 + line	68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING					J	07.00
70.00							70.00
71. 00 72. 00		arem (line	e /U ÷ line :	2)			71. 00 72. 00
73. 00	,	Program (I	line 14 x li	ne 35)			73. 00
74. 00							74. 00
75. 00	Capital-related cost allocated to inpatient routine 26, line 45)	service co	osts (from W	orksheet B, F	Part II, column		75. 00
76. 00							76. 00
77. 00	,						77. 00
78.00			uidar racard	c)			78.00
79. 00 80. 00	1 33 3			· *.	nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitation			,	,		81. 00
82.00		· ·					82.00
83. 00 84. 00	,						83. 00 84. 00
85. 00)				85. 00
86. 00	Total Program inpatient operating costs (sum of lin	es 83 throi					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUTOtal observation bed days (see instructions)	GH COST				3, 574	87. 00
88. 00		ine 27 ÷ li	ine 2)			1, 103. 52	
89. 00	Observation bed cost (line 87 x line 88) (see instr	ructions)				3, 943, 980	89. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2013 To 06/30/2014	Date/Time Prep 11/20/2014 2:4	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 655, 043	20, 331, 265	0. 13058	9 3, 943, 980	515, 040	90.00
91.00 Nursing School cost	0	20, 331, 265	0.00000	3, 943, 980	0	91.00
92.00 Allied health cost	0	20, 331, 265	0.00000	3, 943, 980	0	92.00
93.00 All other Medical Education	0	20, 331, 265	0. 00000	3, 943, 980	0	93. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 07/01/2013	Worksheet D-1
	Component CCN: 15T011		
	Title XVIII	Subprovi der -	PPS

Detr. J. ALL, MONDER COMONENTS 1.00 Paper ALL, MONDER COMONENTS MONTEST days (Including private room days and swing-bed days, excluding newborn) 2,844 1.00 Inpatient days (Including private room days, excluding swing-bed and newborn days) 2,844 2.00 On Inpatient days (Including private room days, excluding swing-bed and newborn days) 2,844 2.00 On the complete this illne. 2,844 2.00 On the complete this illne. 2,844 2.00 On the complete this illne. 2,844 2.00 On the complete district of the cost in the cost i			TI LIE AVIII	I RF	FF3	
		Cost Center Description			1.00	
INPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding swing-bed and newborn days) 2,884 2,00						
2.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00 do not complete this line. 2.854 4.00 4.00 5.						
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) 1. 10 Total swing bed SN type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Kippe inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed Kippe inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed Kippe inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SN type inpatient days applicable to the Program (excluding swing-bed and next on days) including private room days applicable to the Program (excluding swing-bed and next on days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed Not type inpatient days applicable to title				vata naom dava		
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reporting period (if calendar year, enter 0 on this line) 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8	4.00		days)		2, 854	4. 00
1 10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7,00	5.00		days) through December	31 of the cost	0	5. 00
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7 Total swing-bed NF type inpatient days (including private room days) arter December 31 of the cost reporting period (if calendar year, enter 0 on this line) (including private room days applicable to the Program (excluding swing-bed and newborn days) (including private room	7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
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Health Financial Systems	MARION GENERAL H	OSPI TAL	In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		F	eriod: rom 07/01/2013	Worksheet D-1	
		·		Date/Time Prep 11/20/2014 2:4	
		Title XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Total Inpatient CostInpa	Total Average Per atient Days Diem (col. 1 ÷ col. 2)	9	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 Hospi	tal Units	0 0.00	0	0	42. 00
43.00 INTENSIVE CARE UNIT	0	0 0.00	0	0	43.00
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT					44. 00 45. 00
46.00 SURGICAL INTENSIVE CARE UNIT					46. 00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description					47. 00
				1. 00	
48.00 Program inpatient ancillary service 49.00 Total Program inpatient costs (sum				656, 618 3, 336, 870	48. 00 49. 00
PASS THROUGH COST ADJUSTMENTS	<u> </u>	,			
50.00 Pass through costs applicable to Pr	ogram inpatient routine serv	vices (from Wkst. D, sum	of Parts I and	404, 306	50. 00
51.00 Pass through costs applicable to Pr	ogram inpatient ancillary se	ervices (from Wkst. D, su	m of Parts II	27, 200	51. 00
and IV) 52.00 Total Program excludable cost (sum	of lines 50 and 51)			431, 506	52. 00
53.00 Total Program inpatient operating of		ed, non-physician anesthe	tist, and	2, 905, 364	53. 00
medical education costs (line 49 mi TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges				0	54.00
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)				0. 00 0	55. 00 56. 00
57.00 Difference between adjusted inpatie	ent operating cost and targe	t amount (line 56 minus l	ine 53)	0	57. 00
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the	e cost reporting period end	ng 1996 undated and com	nounded by the	0 0. 00	58. 00 59. 00
market basket			pounded by the		
60.00 Lesser of lines 53/54 or 55 from pr 61.00 If line 53/54 is less than the lower			he amount by	0. 00 0	60. 00 61. 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)					
63.00 Allowable Inpatient cost plus incer		ons)		0	62. 00 63. 00
PROGRAM INPATIENT ROUTINE SWING BED 64.00 Medicare swing-bed SNF inpatient ro		31 of the cost reportin	a period (See	0	64. 00
<pre>instructions)(title XVIII only)</pre>					
65.00 Medicare swing-bed SNF inpatient ro	utine costs after December .	31 of the cost reporting	period (See	0	65. 00
66.00 Total Medicare swing-bed SNF inpati	ent routine costs (line 64 p	olus line 65)(title XVIII	only). For	0	66. 00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpation	nt routine costs through Dec	cember 31 of the cost rep	orting period	0	67. 00
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatio	nt routing costs after Docor	mbor 21 of the cost repor	ting poriod	0	68. 00
(line 13 x line 20)		·	triig perrod		
69.00 Total title V or XIX swing-bed NF i PART III - SKILLED NURSING FACILITY				0	69. 00
70.00 Skilled nursing facility/other nurs	ing facility/ICF/MR routine	service cost (line 37)			70. 00
71.00 Adjusted general inpatient routine 72.00 Program routine service cost (line		70 ÷ line 2)			71. 00 72. 00
73. 00 Medically necessary private room co	•	ne 14 x line 35)			73. 00
74.00 Total Program general inpatient rou 75.00 Capital-related cost allocated to i	•	,	rt II column		74. 00 75. 00
26, line 45)	ilpati ent Toutine sei vice cos	SIS (ITOIII WOLKSHEEL B, Pa	it ii, cordiiii		75.00
76.00 Per diem capital-related costs (line 77.00 Program capital-related costs (line	*				76. 00 77. 00
78.00 Inpatient routine service cost (lin					78. 00
79.00 Aggregate charges to beneficiaries			s line 70)		79. 00 80. 00
80.00 Total Program routine service costs 81.00 Inpatient routine service cost per	•	TIME TO MITTUE	3 11110 /7/		81.00
82.00 Inpatient routine service cost limi	,				82.00
83.00 Reasonable inpatient routine service 84.00 Program inpatient ancillary service					83. 00 84. 00
85.00 Utilization review - physician comp	ensation (see instructions)	~b 0E)			85. 00
86.00 Total Program inpatient operating of PART IV - COMPUTATION OF OBSERVATION		Jn 85)			86. 00
87.00 Total observation bed days (see ins	tructions)	0)		0	87. 00
88.00 Adjusted general inpatient routine 89.00 Observation bed cost (line 87 x line		ne 2)			88. 00 89. 00
,	, (ı	٥١	

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2013	5	
		Component	CCN: 15T011	To 06/30/2014	Date/Time Prep 11/20/2014 2:	
		Ti +I	e XVIII	Subprovi der -	PPS	40 piii
		""	0 /////	IRF	113	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH						
90.00 Capital -related cost	532, 735	3, 531, 584	0. 15084	9 0	0	90.00
91.00 Nursing School cost	0	3, 531, 584	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	3, 531, 584	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 531, 584	0.00000	0 0	0	93.00

Health Financial Systems	MARION GENERAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERA	TING COST	Provider CCN: 15001	1 Period: From 07/01/2013	Worksheet D-1
				Date/Time Prepared: 11/20/2014 2:46 pm
		Title XIX	Hospi tal	Cost

				11/20/2014 2:	46 pm
	Cost Contar Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			18, 424	1.00
2. 00	Inpatient days (including private room days, excluding swing-be			18, 424	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days		14, 850	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 21 of the cost	14, 650	5. 00
3.00	reporting period	days) thi odgir beceinbe	1 31 01 the cost	١	3.00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	o	6. 00
	reporting period (if calendar year, enter 0 on this line)			- 1	
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	*h - D (and an include	1 057	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 957	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi		oom dayo,	ا	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent				
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exer during swring bed	days)	2, 209	
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00				0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
19.00	reporting period	till odgir becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			20, 331, 265	
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	1 of the cost reserving	a ported (line (22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	Tor the cost reportin	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
200	7 x line 19)	5. 5. t cost . opc. t.	ing pointed (initial	ا	2 11 00
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		20, 331, 265	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation had ch	arnos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and object vation bed en	ar gcs)	Ö	29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			Ö	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00					34. 00
35. 00					35. 00
36. 00	, , ,				36.00
37. 00					37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 103. 52	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1)			2, 159, 589	39.00
40. 00	Medically necessary private room cost applicable to the Program	•		0	40.00
	Total Program general inpatient routine service cost (line 39 +			2, 159, 589	
			·	•	

Heal th	Financial Systems MARION GENERAL HOSPITAL In L	ieu of Form CMS-2	2552-10
	FATION OF INPATIENT OPERATING COST Provider CCN: 150011 Period:	Worksheet D-1	
	From 07/01/20' To 06/30/20'	13 14 Date/Time Pre	pared:
	Title XIX Hospital	11/20/2014 2:	46 pm
	Cost Center Description Total Total Average Per Program Day	Cost s Program Cost	
	Inpatient Cost∥npatient DaysDiem (col. 1 ÷	(col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 1,649,780 2,209 746.84		42. 00
	Intensive Care Type Inpatient Hospital Units		
43. 00 44. 00	INTENSIVE CARE UNIT 5, 869, 504 3, 817 1, 537. 73 CORONARY CARE UNIT	0 0	43. 00 44. 00
45. 00			45. 00
46. 00			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47. 00
		1. 00	
48. 00		1, 395, 216	
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	3, 554, 805	49.00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I ar	nd 0	50. 00
51. 00			F1 00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51. 00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	
55. 00 56. 00		0.00	55. 00 56. 00
57. 00	· · · · · · · · · · · · · · · · · · ·	0	57. 00
58. 00		0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	ne 0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00	,	0	61. 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)	0	
63. 00	0	63. 00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	9 0	64. 00
/F 00	instructions) (title XVIII only)		/F 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period		67. 00
07.00	(line 12 x line 19)	·	07.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
70.00	26, line 45)	'	70.00
76.00			76.00
77. 00 78. 00			77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost per drem rimitation [Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83.00	Reasonable inpatient routine service costs (see instructions)		83. 00
84. 00 85. 00			84. 00 85. 00
86. 00			86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	2 574	07.00
87. 00 88. 00		3, 574 1, 103. 52	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instructions)	3, 943, 980	

Health Financial Systems	Health Financial Systems MARION GENERAL HO			OSPITAL In Lieu of Form CMS-2			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 1500			Peri od:	Worksheet D-1		
				From 07/01/2013			
				To 06/30/2014	Date/Time Prep 11/20/2014 2:		
		T' 1	1 1/11/			46 piii	
			le XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	2, 655, 043	20, 331, 265	0. 13058	9 3, 943, 980	515, 040	90.00	
91.00 Nursing School cost	0	20, 331, 265	0.00000	0 3, 943, 980	0	91.00	
92.00 Allied health cost	0	20, 331, 265	0.00000	0 3, 943, 980	0	92.00	
93.00 All other Medical Education	0	20, 331, 265	0.00000	0 3, 943, 980	0	93. 00	

Health Financial Systems	MARION GENERAL HOSPITAL		In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi o		Peri od: From 07/01/2013	Worksheet D-1	
	Compor	nent CCN: 15T011		Date/Time Prepared: 11/20/2014 2:46 pm	
		Title XIX	Subprovider -	Cost	

AAL PROVIDER COMPONENTS 1.00 AAL COMPONENTS 1.0			TI LIE XIX	I RF	Cost	
PART - ALL PROVIDER COMPONENTS		Cost Center Description				
MATLETT DAYS		PART I _ ALL PROVINER COMPONENTS			1.00	
1.00 Impatient days (including private room days)						
2.00 Private room days (excluding swing-bed and observation bed days) Fryou have only private room days 4.00 Semi-private room days (excluding swing-bed and observation bed days) 6.00 7.00						
do not complete this line. do				veta room dave		
Semi-private room days (excluding swing-bed and observation bed days) 1	3.00		i. II you have only pri	vate room days,	U	3.00
reporting period. 1.00 Total swing-bed SNP type inpatient days. (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed NP type inpatient days. (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNP type inpatient days. (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNP type inpatient days applicable to the Program (excluding swing-bed and newborn days) 1.00 Swing-bed SNP type inpatient days applicable to the Program (excluding private room days) 1.00 Swing-bed SNP type inpatient days applicable to the program (excluding swing-bed and here) 1.00 Swing-bed SNP type inpatient days applicable to the Program (excluding private room days) after swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) after swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) after swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) after swing-bed MP type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed MP type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed MP type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed MP type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 1.00 Swing-bed SNP type services applicable to services through December 31 of the cost reporting period (including private room days) 1.00 Swing-bed cost applicable to SNP type services through December 31 of the cost reporting period (line Swing-bed dost applicable to SNP type services	4.00		days)		2, 854	4. 00
10tal swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (Ir calendar year, enter 0 on this Irine) 7.00	5.00		days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 1.00	6 00		days) after December 3	R1 of the cost	0	6 00
1.00 Total swingbed NF type Inpatient days (including private room days) after December 31 of the cost 0 7.00	0.00		uays) arter becember t	or the cost	U	0.00
10 10 10 10 10 10 10 10	7.00		days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 Total inpatient days including perivate room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Iotal nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 SWING-BOR DOUSTRUET 18.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period 19.00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical dirate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical dirate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical dirate for swing-bed NF services after December 31 of the cost reporting period (line 8 or NF type services after December 31 of the cost reporting period (line 8 or NF type services through December 31 of the cost reporting period (line	0.00	1 31	dava) aftan Dagamban 21	1 of the cost	0	0.00
7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00 10	8.00		lays) at ter becember 3	i oi the cost	U	8.00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10.00	9.00		the Program (excluding	swi ng-bed and	98	9. 00
through December' 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed Ne Type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed Ne Type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed Ne Type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed Ne Type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Neurory days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Neurory days (title V or XIX only) 19.00	10.00		. (:!		0	10.00
11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nersery days (title V or XIX only) 17.00 Medically necessary private room days applicable to services through December 31 of the cost 17.00 Nersery days (title V or XIX only) 17.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost 17.00 Medical rate for swing-bed SMF services applicable to services after December 31 of the cost 18.00 reporting period 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x 11 in 17) 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x 11 in 18) 19.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x 11 in 18) 19.00 Medical d rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x 11 in 18) 19.00 Medical d rate for swing-bed	10.00			oom days)	0	10.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0, 14.00 Nursery days (title V or XIX only) 0, 15.00 Nursery days (title V or XIX only) 0, 16.00 Nursery days (title V or XIX o	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11. 00
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 531, 584) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	The 28)			
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 531, 584) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,531,584) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 36.00 36.00 37.00 3				tions)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 237. 42 38. 00 Program general inpatient routine service cost (line 9 x line 38) 121, 267 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		9	31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 237. 42 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 121, 267 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			d private room cost dif	fferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 237. 42 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 121, 267 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)			.,,	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 237. 42 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 121, 267 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 121, 267 39.00 40.00	38 00				1 227 42	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			*			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 121,267 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)		121, 267	41. 00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 1500	From 07/01/2013			
			Component CCN: 15T0		11/20/2014 2:		
			Title XIX	Subprovi der - I RF	Cost		
	Cost Center Description	Total Inpatient Cost Inp	Total Average Datient Days Diem (col col. 2	. 1 ÷	Program Cost (col. 3 x col. 4)		
		1.00	2.00 3.00		5. 00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	42. 00	
43. 00	INTENSIVE CARE UNIT	0	ol	0.00) 0	43.00	
44. 00	CORONARY CARE UNIT					44. 00	
	BURN INTENSIVE CARE UNIT					45. 00	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)					46. 00 47. 00	
17.00	Cost Center Description					17.00	
					1. 00		
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				40, 132 161, 399		
49.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 40) (Sei	e mstructrons)		101, 399	49.00	
50. 00	Pass through costs applicable to Program inp	atient routine se	rvices (from Wkst. D,	sum of Parts I and	0	50. 00	
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary:	services (from Wkst.	D, sum of Parts II	0	51.00	
52. 00	Total Program excludable cost (sum of lines	50 and 51)			0	52. 00	
53. 00	Total Program inpatient operating cost exclu		ted, non-physician an	esthetist, and	0	53. 00	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges				0	54.00	
	, 3				0.00		
	Target amount (line 54 x line 55)		-t (1! F/ -!	1: 52)	0		
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	et amount (line 56 mi	nus iine 53)	0		
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period en	ding 1996, updated an	d compounded by the	1		
	market basket						
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				0.00		
01.00	which operating costs (line 53) are less that	n expected costs				01.00	
	amount (line 56), otherwise enter zero (see instructions)						
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)		0		
03. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	cire (acc rinati deti	10113)			05.00	
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the cost rep	orting period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost renor	ting period (See	0	65. 00	
03. 00	instructions) (title XVIII only)	ts arter becomber	or the cost repor	tring perrou (see		05.00	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)(title	XVIII only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through D	ecember 31 of the cos	t reporting period	0	67. 00	
07.00	(line 12 x line 19)	c costs till odgir b	occimber of or the cos	t reporting perrod		07.00	
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of the cost	reporting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + Line 68)		0	69.00	
	PART III - SKILLED NURSING FACILITY, OTHER N					1	
	Skilled nursing facility/other nursing facil	-	,	37)		70.00	
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		e 70 ÷ TTNe 2)			71.00	
73. 00	Medically necessary private room cost applic		line 14 x line 35)			73. 00	
74.00	Total Program general inpatient routine serv					74.00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from Worksheet	B, Part II, column		75. 00	
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				76. 00	
	Program capital-related costs (line 9 x line					77. 00	
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		vider records)			78. 00 79. 00	
	Total Program routine service costs for comp			minus line 79)		80.00	
81. 00	Inpatient routine service cost per diem limi	tati on	•	•		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	(see instructions				85. 00	
86. 00	Total Program inpatient operating costs (sum		ugh 85)			86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions				0	87. 00	
		,			1	1	
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ li	ine 2)		0.00	88. 00	

Health Financial Systems	MARION GENERA	AL HOSPITAL)SPITAL In L			ieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1		
				From 07/01/2013			
		Component	CCN: 15T011	To 06/30/2014	Date/Time Prep		
		Ti t	le XIX	Subprovi der -	Cost	то ріп	
				IRF			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1. 00	2. 00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (
90.00 Capital -related cost	532, 735	3, 531, 584	0. 15084	9 0	0	90. 00	
91.00 Nursing School cost	0	3, 531, 584	0.00000	0 0	0	91. 00	
92.00 Allied health cost	0	3, 531, 584	0.00000	0 0	0	92. 00	
93.00 All other Medical Education	0	3, 531, 584	0.00000	0 0	0	93. 00	

Health Financial Systems	MARION GENERAL HOSPITAL			eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150011	Peri od: From 07/01/2013	Worksheet D-3	
			To 06/30/2014		nared:
			10 00/00/2011	11/20/2014 2:	
	Ti tl	e XVIII	Hospi tal	PPS	•
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			8, 763, 979		30.00
31. 00 03100 I NTENSI VE CARE UNI T			3, 971, 510		31.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					1
50.00 05000 OPERATING ROOM		0. 16676			
51.00 05100 RECOVERY ROOM		0.00000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 36387			
57.00 05700 CT SCAN		0. 04728			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 25300			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 47056			
60. 00 06000 LABORATORY		0. 42018			
60. 01 06001 0NC0L0GY		0. 35313			
60. 02 06002 RADI ATI ON ONCOLOGY		0.00000		0	60. 0
65. 00 06500 RESPI RATORY THERAPY		0. 52961	· ·		65. 0
66. 00 06600 PHYSI CAL THERAPY		0. 24413			
69. 00 06900 ELECTROCARDI OLOGY		0. 23833			
69. 01 06901 CARDI AC REHAB		0. 56582		181	69. 0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000		0	72.0
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 25023	3, 350, 628	838, 451	73.0
OUTPATIENT SERVICE COST CENTERS					4
90. 00 09000 CLI NI C		3. 16138		_	, , , , ,
91. 00 09100 EMERGENCY		0. 16416			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 53162		1	1 / 0
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.00000	00 0	0	92. 0°
OTHER REIMBURSABLE COST CENTERS		ı		1	
DE ON MOSON AMBILLANCE SERVICES		I		I .	05 0

95.00

201. 00 202. 00

7, 187, 225 200. 00

31, 867, 534

31, 867, 534

95. 00 09500 AMBULANCE SERVICES

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

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

200.00

201. 00 202. 00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIO	MARION GENERAL HOS		CCN: 150011	Period:	worksheet D-3	
INPATTENT ANCILLARY SERVICE COST APPORTED	VIVIEIV I	Provider	CCN: ISOUTT	From 07/01/2013	worksneet D-3	
		Component	t CCN: 15T011		Date/Time Pre 11/20/2014 2:	pared: 46 pm
		Ti tl	e XVIII	Subprovi der - I RF	PPS	•
Cost Center Description	· ·		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CEN	EDC		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS	ERS			0		30.00
31. 00 03100 NTENSI VE CARE UNI T				Ö		31.00
40. 00 04000 SUBPROVI DER - I PF				0		40.00
41. 00 04100 SUBPROVI DER - RF				2, 781, 245		41.00
42. 00 04200 SUBPROVI DER				0		42.00
43. 00 04300 NURSERY						43. 00
ANCILLARY SERVICE COST CENTERS						ļ
50. 00 05000 OPERATI NG ROOM			0. 1667		65	
51. 00 05100 RECOVERY ROOM			0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN			0. 3638 0. 0472		11, 851	
58. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (M	DI)		0.0472	· ·	1, 846 3, 440	
59. 00 05900 CARDI AC CATHETERI ZATI ON	NI)		0. 2330		3, 440	
60. 00 06000 LABORATORY			0. 4201		51, 584	
60. 01 06001 0NCOLOGY			0. 3531		85	
60. 02 06002 RADIATION ONCOLOGY			0.0000		0	60.02
65. 00 06500 RESPIRATORY THERAPY			0. 5296	11 43, 152	22, 854	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 2441		492, 149	66. 00
69. 00 06900 ELECTROCARDI OLOGY			0. 2383		5, 715	
69. 01 06901 CARDI AC REHAB			0. 5658		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO F			0.0000		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	5		0.0000		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS			0. 2502	37 252, 448	63, 172	73.00
90. 00 09000 CLINIC			3. 1613	83 0	0	90.00
91. 00 09100 EMERGENCY			0. 1641			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTING	T PART)		0. 5316		0	1
92.01 09201 OBSERVATION BEDS (DISTINCT PA	RT)		0.0000	00 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	24.00			0.5/7	,_,	95. 00
Total (sum of lines 50-94 and		! (1)		2, 567, 419	656, 618	
	rvices-Program only charges (I	ine 61)		0		201. 00
202.00 Net Charges (line 200 minus l	THE ZUI)		I	2, 567, 419	l	202. 00

PARTIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CCN: 150011	Peri od:	Worksheet D-3	,
			From 07/01/2013 To 06/30/2014	Date/Time Pre	
·	Ti tl	e XIX	Hospi tal	11/20/2014 2: Cost	46 pr
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
	-	1. 00	2. 00	2) 3. 00	+
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	1
D. 00 03000 ADULTS & PEDI ATRI CS			2, 011, 157		30.
1. 00 03100 I NTENSI VE CARE UNI T			837, 421		31.
0. 00 04000 SUBPROVI DER - 1 PF			0		40.
1. 00 04100 SUBPROVI DER - I RF			0		41.
2. 00 04200 SUBPROVI DER			0		42.
3. 00 04300 NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS					4
0.00 O5000 OPERATI NG ROOM		0. 1667		490, 870	
. 00 05100 RECOVERY ROOM		0.0000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C 7. 00 05700 CT SCAN		0. 3638 0. 04728		53, 720 12, 582	
BOO O5700 CT SCAN BOO O5800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2530		7, 374	
2. 00 05900 CARDI AC CATHETERI ZATI ON		0. 4705		154, 143	
. 00 06000 LABORATORY		0. 42018		230, 299	
0. 01 06001 0NCOLOGY		0. 3531		1, 934	
. 02 06002 RADI ATI ON ONCOLOGY		0.0000		0	
6. 00 06500 RESPI RATORY THERAPY		0. 5296	11 130, 308	69, 013	65
o. 00 06600 PHYSI CAL THERAPY		0. 2441		33, 813	66
0. 00 06900 ELECTROCARDI OLOGY		0. 2383		48, 226	
0. 01 06901 CARDI AC REHAB		0. 56582		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	1
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	1
. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 2502	37 739, 258	184, 990	73
0. 00 O9000 CLINIC		3. 1613	83 0	0	90
. 00 09100 EMERGENCY		0. 1641		108, 252	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5316		0	
. 01 09201 OBSERVATI ON BEDS (DI STINCT PART)		0. 00000		Ö	
OTHER REIMBURSABLE COST CENTERS					1
. 00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50-94 and 96-98)			6, 137, 259	1, 395, 216	
D1.00 Less PBP Clinic Laboratory Services-Program only ch	harges (line 61)		0		201
02.00 Net Charges (line 200 minus line 201)			6, 137, 259		202

	Financial Systems MARION GENERAL HOS ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150011	Peri od:	eu of Form CMS-: Worksheet D-3	
		Componen ⁻	t CCN: 15T011	From 07/01/2013 To 06/30/2014	Date/Time Pre	
		Ti t	le XIX	Subprovi der -	11/20/2014 2: Cost	46 pm
			I	IRF		
	Cost Center Description		Ratio of Cos	t Inpatient Program	Inpatient Program Costs	
			To Charges	3	(col. 1 x col.	
				Charges	2)	
			1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER - I RF			130, 661		41. 00
	04200 SUBPROVI DER			0		42. 00
43.00	04300 NURSERY			0		43. 00
	ANCILLARY SERVICE COST CENTERS				1	
	05000 OPERATING ROOM		0. 16676			
	05100 RECOVERY ROOM		0.00000		_	
	05400 RADI OLOGY-DI AGNOSTI C		0. 36387			
	05700 CT SCAN		0. 04728		1	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 25300 0. 47056			
	06000 LABORATORY		0. 47056		_	
	06001 ONCOLOGY		0. 35313		1	1
	06002 RADI ATI ON ONCOLOGY		0. 00000		0	60.02
	06500 RESPI RATORY THERAPY		0. 5296		_	
	06600 PHYSI CAL THERAPY		0. 24413			
	06900 ELECTROCARDI OLOGY		0. 23833			
	06901 CARDI AC REHAB		0. 56582		l .	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	00	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000	00	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 25023	37, 143	9, 295	73. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		3. 16138		l .	90.00
	09100 EMERGENCY		0. 16416		l .	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 53162			
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)		0.00000	00 0	0	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS				ı	05.66
	09500 AMBULANCE SERVICES			157 004	40.400	95. 00
200.00		ino 41)		157, 991	40, 132	200. 00
201.00		ine oi)		157, 991		
202.00	Net Charges (Time 200 minus Time 201)			157, 991	I	202. 00

	ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150011	Peri od: From 07/01/2013 To 06/30/2014		
		T: +1	o VVIII		11/20/2014 2:	46 pm
		11 (1	e XVIII before 1/1	Hospi tal on/after 1/1	PPS	
		0	1.00	1. 01	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		3, 158, 5 ⁻	٦		1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		10, 599, 75	50		1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)			0		1. 03
2.00	Outlier payments for discharges. (see instructions)		50, 52	22		2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)			0		2. 01 2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost		87.2	0 21		3. 00 4. 00
	reporting period (see instructions) Indirect Medical Education Adjustment					
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.0	00		5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new		0. (00		6. 00
7. 00	programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as		0. (00		7. 00
7. 01	specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the		0. (00		7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for		0. (00		8. 00
	allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069,					
8. 01	August 1, 2002. The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		0. (00		8. 01
8. 02	straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506		0. 0	00		8. 02
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0. 0	00		9. 00
10. 00	lines (8, 8,01 and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records		0. (00		10. 00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		0. (0. (11. 00 12. 00
13.00	Total allowable FTE count for the prior year.		0. (00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0. (00		14. 00
15. 00	Sum of lines 12 through 14 divided by 3.		0. (15. 00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital		0. (0. (16. 00 17. 00
18. 00 19. 00	closure Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by		0. 0 0. 00000			18. 00 19. 00
20. 00	line 4). Prior year resident to bed ratio (see instructions)		0. 00000	00		20. 00
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)		0. 00000	0		21. 00 22. 00
23. 00	Indirect Medical Education Adjustment for the Add-on for Sect Number of additional allopathic and osteopathic IME FTE	ion 422 of t	he MMA 0.0	00		23. 00
24. 00 25. 00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter		0. (0. (24. 00 25. 00
26. 00	the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)		0. 00000	20		26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 00000			27. 00
28. 00 29. 00	IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28)			0		28. 00 29. 00
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part		5. 3			30.00
	A patient days (see instructions)					
	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		22. 4 27. 7			31. 00 32. 00

CALCOL	ATION OF REIMBURSEMENT SETTLEMENT		Trovi dei		From 07/01/2013 To 06/30/2014	Part A Date/Time Pre 11/20/2014 2:	
			Ti tl	le XVIII	Hospi tal	PPS	
		-		before 1/1	on/after 1/1	2.00	
33. 00	Allowable disproportionate share percentage (instructions)	(see	0	1.00	1. 01	2. 00	33. 00
34. 00	Disproportionate share adjustment (see instru	uctions)		705, 14	15		34.00
				Prior to		On/After	
		0		0ctober 1 1.00	1. 01	0ctober 1 2.00	
	Uncompensated Care Adjustment			1.00	1.01	2.00	
35.00	Total uncompensated care amount (see					9, 046, 380, 143	35. 00
35. 01	instructions) Factor 3 (see instructions)					0. 000135796	35. 01
35. 02	Hospital uncompensated care payment (If					1, 228, 459	1
	line 34 is zero, enter zero on this line)						
35. 03	(see instructions) Pro rata share of the hospital uncompensated					918, 820	35. 03
33. 03	care payment amount (see instructions)					710, 020	33.03
36. 00	Total uncompensated care (sum of columns 1			918, 82	20		36. 00
	and 2 on line 35.03) Additional payment for high percentage of ESR	D beneficiary d	li scharges				-
40.00	Total Medicare discharges on Worksheet S-3,		gee		0		40. 00
	Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)						
41. 00	Total ESRD Medicare discharges excluding				0 0		41.00
	MS-DRGs 652, 682, 683, 684 an 685. (see						
41. 01	instructions) Total ESRD Medicare covered and paid				0		41. 01
41.01	discharges excluding MS-DRGs 652, 682, 683,						41.01
40.00	684 an 685. (see instructions)						40.00
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.0	00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see				0		43. 00
	instructions)						
44. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7			0.00000	00		44.00
	days)						
45. 00	Average weekly cost for dialysis treatments			0.0	0.00		45. 00
46. 00	(see instructions) Total additional payment (line 45 times line				0		46. 00
	44 times line 41.01)			15 400 75			
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed			15, 432, 75 13, 470, 97			47. 00 48. 00
101 00	by SCH and MDH, small rural hospitals			10,170,77			10.00
40.00	only. (see instructions)			15 422 75	.0		40.00
49. 00	Total payment for inpatient operating costs SCH and MDH only (see instructions)			15, 432, 75	50		49. 00
50.00	Payment for inpatient program capital (from			1, 106, 80	08		50.00
51. 00	Worksheet L, Parts I, II, as applicable) Exception payment for inpatient program				0		51.00
31.00	capital (Worksheet L, Part III, see						31.00
	instructions)						
52. 00	Direct graduate medical education payment (from Worksheet E-4, line 49 see				0		52. 00
	instructions).						
53. 00	Nursing and Allied Health Managed Care payment				0		53. 00
54.00	Special add-on payments for new technologies				0		54.00
55. 00	Net organ acquisition cost (Worksheet D-4				0		55. 00
56. 00	Part III, col. 1, line 69) Cost of physicians' services in a teaching				0		56.00
	hospital (see intructions)						
57. 00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30				0		57. 00
58. 00	through 35). Ancillary service other pass through costs				0		58. 00
	from Worksheet D, Part IV, col. 11 line 200)						
59. 00	Total (sum of amounts on lines 49 through 58)			16, 539, 55	98		59. 00
60.00	Primary payer payments			15, 03	30		60.00
61. 00	Total amount payable for program			16, 524, 52	28		61. 00
62. 00	beneficiaries (line 59 minus line 60) Deductibles billed to program beneficiaries			1, 732, 00	00		62. 00
63. 00	Coinsurance billed to program beneficiaries			25, 69			63.00
64.00	Allowable bad debts (see instructions)			123, 56			64.00
65. 00	Adjusted reimbursable bad debts (see instructions)			80, 32	:0		65. 00
	 /			•	1	1	1

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150011

						11/20/2014 2:	46 pm
			litl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1.00	1. 01	2.00	
66. 00	Allowable bad debts for dual eligible			7, 204			66. 00
	beneficiaries (see instructions)			., =			
67. 00	Subtotal (line 61 plus line 65 minus lines			14, 847, 152			67. 00
07.00	62 and 63)			14, 047, 132			07.00
40.00				,			40.00
68. 00	Credits received from manufacturers for			U			68. 00
	replaced devices applicable to MS-DRG (see						
	instructions)						
69. 00	Outlier payments reconciliation (sum of			0			69. 00
	lines 93, 95 and 96). (For SCH see						
	instructions)						
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70.00
	(SPECIFY)						
70. 50	RURAL DEMONSTRATION PROJECT			0			70. 50
70. 92	Bundled Model 1 discount amount			-			70. 92
70. 72	HVBP incentive payment (see instructions)			-20, 797			70. 93
	1						1
70. 94	Hospi tal readmissions reduction adjustment			0			70. 94
	(see instructions)						
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	pri or to 10/1)						
70. 97	Low volume adjustment for federal fiscal		0	0			70. 97
, 0. , ,	year (yyyy) (Enter in column 0 the		· ·				7 0. 77
	corresponding federal year for the period						
	ending on or after 10/1)						
70.00							70. 98
70. 98	Low Volume Payment-3			44.004.055			
71. 00	Amount due provider (line 67 minus lines 68			14, 826, 355			71. 00
	plus/minus lines 69 & 70)						
71. 01	Sequestration adjustment (see instructions)			296, 527			71. 01
72.00	Interim payments			14, 887, 671			72. 00
73.00	Tentative settlement (for contractor use			0			73. 00
	only)						
74.00	Balance due provider (Program) line 71 minus			-357, 843			74.00
	lines 71.01, 72 and 73						
75. 00	Protested amounts (nonallowable cost report			3, 031, 142			75. 00
73.00	items) in accordance with CMS Pub. 15-2,			3, 031, 142			75.00
	chapter 1, §115.2						
						1	-
00.00	TO BE COMPLETED BY CONTRACTOR				I		
90. 00	Operating outlier amount from Worksheet E,			0			90. 00
	Part A line 2 (see instructions)						
91.00	Capital outlier from Worksheet L, Part I,			0			91. 00
	line 2						
92.00	Operating outlier reconciliation adjustment			0			92. 00
	amount (see instructions)						
93.00	Capital outlier reconciliation adjustment			0			93. 00
70.00	amount (see instructions)						70.00
94. 00	The rate used to calculate the time value of			0.00			94.00
74. UU]			74.00
05.00	money (see instructions)			_			05.00
95. 00	Time value of money for operating expenses			0			95. 00
	(see instructions)					1	
96. 00	Time value of money for capital related			0			96. 00
	expenses (see instructions)						

	ATION OF DSH PAYMENT PERCENTAGE		Provi der		Peri od:	Worksheet DSH	
					From 07/01/2013 To 06/30/2014	Date/Time Pre 11/20/2014 2:	
				e XVIII	Hospi tal	PPS	
		Original .mcrxA Values	djusted .mcax Values	HFS Look Up	Overri de Value	Revi sed Value	
		1.00	2. 00	3. 00	4. 00	5. 00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1. 00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line	5. 39	0. 00	0. 0	0.00	0. 00	1.00
2. 00	30 - Revised from CMS) Percentage of Medicaid patient days to total days (From line 27)	22. 40	0. 00			22. 40	2. 00
3. 00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	27. 79	0. 00			22. 40	3. 00
4. 00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4. 00
5. 00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	87. 21	0. 00			87. 21	5. 00
6. 00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, Line 33)	12. 14	0. 00			7. 69	6. 00
7. 00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7. 00
8. 00 9. 00	S-2, Line 22 Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes No				Yes No	8. 00 9. 00
10. 00 11. 00	S-2, Line 45 Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I,	No Yes				No Yes	10. 00 11. 00
12. 00	line 1 geater than -0-) Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0. 00	0. 00	0.0	0.00	0.00	12. 00
13. 00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13. 00
14. 00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS) CALCULATION OF THE PERCENTAGE OF MEDICAID DAY	1. 86	0.00	0.0	0. 00	0.00	14. 00
15. 00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1, 957	0			1, 957	15. 00
16. 00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	497	0			497	16. 00
17. 00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17. 00
18. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18. 00
18. 01 19. 00	N/A Medicaid HMO days (Worksheet S-2, line 24,	0 2, 256	0			0 2, 256	18. 01 19. 00
20. 00	column 5) Other Medicaid days (Worksheet S-2, line 24,	O	0			0	20. 00
21. 00	column 6) Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	4, 710	0			4, 710	21. 00
22. 00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	20, 876	0			20, 876	22. 00
23. 00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	O	0			0	23. 00
24. 00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	152	0			152	24. 00
25. 00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	o	0			0	25. 00
26. 00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	21, 028	0			21, 028	26. 00
27. 00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22. 40	0. 00			22. 40	27. 00

Health Financial Systems	7				In Lieu of Form CMS-2552-10		
CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 150011		Peri od:	Worksheet DSH	
					From 07/01/2013		
					To 06/30/2014	Date/Time Pre	
						11/20/2014 2:	46 pm_
			Ti tl	e XVIII	Hospi tal	PPS	
	Ori gi nal . r	ncrx \	Val ues	Adj usted	. mcax Values	Revi sed	
	Condi ti on	Per	centage	Condi ti on	Percentage	Condi ti on	
	1.00		2.00	3. 00	4. 00	5. 00	
CALCULATION OF MAYIMUM DSH DAYMENT DEDCENTACE	-						

				104111		11/20/2014 2.	40 piii
				e XVIII	Hospi tal	PPS	
		Original .n	ncrx Values	Adjusted .	mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2. 00	3.00	4. 00	5. 00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					•	
28. 00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and	True	12. 14		0.00	True	28. 00
	line 3						
20 00		Fal se	0.00		0.00	Fal se	29. 00
29.00	of the difference between 15% and line 3	i ai se	0.00		0.00	raise	
30.00	Line 28 or 29 as applicable		12. 14		0.00		30. 00
31.00	If Urban and fewer than 100 beds, Rural and		12. 14		0.00		31.00
	fewer than 500 beds, or an SCH the lower of						
	line 30 or .1200, if RRC, MDH or otherwise						
	enter line 30.						
		Original .mcrx		HFS Look Up	Overri de Value	Revi sed Value	
		Val ues	Val ues				
		1.00	2. 00	3.00	4. 00	5. 00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle	Fal se				Fal se	32. 00
	ammendment? (Worksheet S-2, Part I, Line 22,						
	col umn 2 = "Y")						
33.00	Is This a Rural Referral Center? (Worksheet	True				True	33. 00
	S-2, Part I, line 116, column 1 = "Y")						
34.00	Is this a Medicare Dependant Hospital?	Fal se				Fal se	34.00
	(Worksheet S-2, Part I, Line 37 greater than						
	-0-)						
35.00	Is this a Sole Cummunity hospital?	True				True	35. 00
	(Worksheet S-2, Part I, Line 35 greater than						
	-0-)						
36.00	Is this an Urban or Rural hospital?	Rural				Rural	36. 00
	(Worksheet S-2, Part I, Line 26, Column 1,						
	Urban=1, Rural =2)						

Health Financial Systems	MARION GENERAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150011	From 07/01/2013 To 06/30/2014	Worksheet DSH Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospi tal	PPS

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6. 00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28. 00	If line 3 is greater than 20.2% - 5.88% plus	7. 69				28. 00
	82.5% of the difference between 20.2% and					
	line 3					
29. 00	If line 3 is less than 20.2% - 2.5% plus 65%	0. 00				29. 00
	of the difference between 15% and line 3					
30. 00	Line 28 or 29 as applicable	7. 69				30. 00
31.00	If Urban and fewer than 100 beds, Rural and	7. 69				31. 00
	fewer than 500 beds, or an SCH the lower of					
	line 30 or .1200, if RRC, MDH or otherwise					
	enter line 30.					

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 07/01/2013 Part A Exhibit 4 To 06/30/2014 Date/Time Prepared: 11/20/2014 2:46 pm Provider CCN: 150011

						0 00/30/2014	11/20/2014 2:	
					e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1. 00	DRG amounts other than outlier	1. 00	1.00	2. 00	3.00	4.00	5. 00 0	1. 00
1.00	payments	1.00	٥	0		,	U	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1,	1. 01	3, 158, 513	0	3, 158, 513	0	3, 158, 513	1. 01
1. 02	2013 DRG amounts other than outlier	1. 02	10, 599, 750	0	(10, 599, 570	10, 599, 570	1. 02
	payments for discharges occurring on or after October 1, 2013							
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1. 03	O	0	(0	0	1. 03
2. 00	Outlier payments for discharges (see instructions)	2. 00	50, 522	0	22, 644	27, 879	50, 523	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	(0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	(0	0	4. 00
	Indirect Medical Education Adju	ıstment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	(0	0	6. 00
	instructions) Indirect Medical Education Adju	etmont for the	Add on for So	ction 122 of t	ho MMA			
7. 00	Amount from Worksheet E Part	27. 00	0. 000000	0.000000		0. 000000		7. 00
8. 00	A, line 27 (see instructions) IME adjustment (see	28. 00	0	0. 000000	0.00000	0.00000	0	8. 00
9. 00	instructions) Total IME payment (sum of	29. 00	0	0			0	9. 00
7. 00	lines 6 and 8) Disproportionate Share Adjustme		Ĭ				0	7. 00
10. 00	Allowable disproportionate	33. 00	0. 1214	0. 1214	0. 1214	0. 1214		10. 00
10. 00	share percentage (see instructions)	33.00	0. 1214	0. 1214	0. 121-	0. 1214		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	705, 145	0	383, 448	321, 697	705, 145	11. 00
11. 01	Uncompensated care payments	36.00	918, 820	0	(918, 820	918, 820	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	46.00	beneficiary	di scharges 0			0	12. 00
	(see instructions)			0				
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (to	47. 00 48. 00	15, 432, 750 13, 470, 970	0	3, 564, 605 (11, 868, 145 0	15, 432, 750 0	13. 00 14. 00
	be completed by SCH and MDH, small rural hospitals only (see instructions)							
15. 00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49. 00	15, 432, 750	0	3, 564, 605	11, 868, 145	15, 432, 750	15. 00
16. 00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50. 00	1, 106, 808	0	253, 674	853, 134	1, 106, 808	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	(O	0	17. 00
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	O	0	(0	0	18. 00
19. 00	SUBTOTAL			0	3, 818, 279	12, 721, 279	16, 539, 558	19. 00

Heal th	Financial Systems	MARION GENERAL HOSPITAL					In Lieu of Form CMS-2552-10			
LOW VOLUME CALCULATION EXHIBIT 4			Prov		Provi der CCN: 150011		Period: From 07/01/2013 To 06/30/2014		pared:	
					Ti tl	e XVIII	Hospi tal	PPS		
		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, 097, 818		0	250, 56	2 847, 256	1, 097, 818	20. 00	
20 01	Model 4 BPCI Canital DRG other	1 01	Ι		0	l	ol o	0	20 01	

		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, 097, 818	0	250, 562	847, 256	1, 097, 818	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	0	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	8, 990	0	3, 112	5, 877	8, 989	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	o	0	0	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	o	0	0	0	0	23. 00
	adjustment (line 20 times line							
	22)							
24.00	Allowable disproportionate	10. 00	0. 0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11. 00	0	0	0	0	0	25. 00
	adjustment (line 20 times line							
	24)							
26.00	Total prospective capital	12.00	1, 106, 808	0	253, 674	853, 134	1, 106, 808	26. 00
	payments (sum of lines 20-21,							
	23 and 25)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 000000	0. 000000		27. 00
28. 00	Low volume adjustment	70. 96			0		0	28. 00
	(transfer amount to W/S E Part							
	A line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to W/S E Part							
	A line)							
100.00	Transfer low volume		Y					100. 00
	adjustments to W/S E Part A.							

USPI TAL	In Lie	u of Form CMS-2	552-10
Provi der CCN: 150011		Part B Date/Time Prep	
Title XVIII	Hospi tal	PPS	
_		Provider CCN: 150011 Period: From 07/01/2013 To 06/30/2014	Provider CCN: 150011

			10 06/30/2014	11/20/2014 2:	
		Title XVIII	Hospi tal	PPS	40 piii
		THE AVIII	nospi tai	113	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			8, 753	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		17, 370, 854	2. 00
3.00	PPS payments			16, 270, 360	3. 00
4.00	Outlier payment (see instructions)			87, 840	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	1
8. 00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Worksheet D, Pa	rt IV, column 13, line	e 200	0	1
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 753	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			20.550	10.00
12.00	Ancillary service charges	0 001 4)		28, 559	1
13. 00 14. 00	Organ acquisition charges (from Worksheet D-4, Part III, line 6	9, (01. 4)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			28, 559	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for				16.00
10.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services t	on a chargebasi's		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			28, 559	1
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	19, 806	1
	instructions)		, (
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)		, ,		
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		8, 753	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			16, 358, 200	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			3, 499, 421	1
27. 00	Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus t	ne sum of lines 22 and	1 23} (TOT CAH,	12, 867, 532	27. 00
20 00	see instructions) Direct graduate medical education payments (from Worksheet E-4,	line EO)		0	28. 00
28. 00 29. 00	ESRD direct medical education costs (from Worksheet E-4, line 3	•			ı
30. 00	Subtotal (sum of lines 27 through 29)	0)		12, 867, 532	1
31. 00	Primary payer payments			2, 497	1
32. 00	Subtotal (line 30 minus line 31)			12, 865, 035	1
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		12/000/000	02.00
33. 00	Composite rate ESRD (from Worksheet I-5, line 11)	-,		0	33. 00
34.00	Allowable bad debts (see instructions)			587, 860	1
35.00	Adjusted reimbursable bad debts (see instructions)			382, 109	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		292, 129	36.00
37.00	Subtotal (see instructions)			13, 247, 144	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			-118	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instrud	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			13, 247, 262	40. 00
40. 01	Sequestration adjustment (see instructions)			264, 945	1
41. 00	Interim payments			13, 093, 514	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)	' II ONG D.I. 45 O		-111, 197	•
44. 00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with two Pub. 15-2,	спартег Т,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)				
92. 00	The rate used to calculate the Time Value of Money			0.00	1
93. 00	Time Value of Money (see instructions)			0.00	1
94. 00	Total (sum of lines 91 and 93)			0	
	· · · · · · · · · · · · · · · · · · ·			Overri des	
				1. 00	
	WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0	112. 00

| Peri od: | Worksheet E-1 | From 07/01/2013 | To 06/30/2014 | Date/Time Prepared: | 11/20/2014 2: 46 pm Health Financial Systems MARANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150011

					11/20/2014 2: 4	46 pm
		Ti	tle XVIII	Hospi tal	PPS	
		Inpati	ent Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		14, 790, 9	75	12, 602, 294	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					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	06/30/2014	96, 6	96 06/30/2014	331, 120	3. 01
3.02				0 01/30/2014	160, 100	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54			0, ,	0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		96, 6		491, 220	3. 99
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		14, 887, 6	71	13, 093, 514	4. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 04	Program to Provider	ı				F 04
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5. 02 5. 03				0	0	5. 02
5.03	Provider to Program		_	U	0	5. 03
5. 50	TENTATI VE TO PROGRAM			O	0	5. 50
5. 51	TELLINITE TO TROOTS III			0		5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		357.8	٦	111, 197	6. 01
6. 02 7. 00	Total Medicare program liability (see instructions)		14, 529, 8		12, 982, 317	7. 00
7.00	Tiotal Medicale program Habitity (see Histructions)		14, 329, 8	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
0.00	None of Contractor		0	1. 00	2.00	0.00
8. 00	Name of Contractor	l			1	8. 00

Health Financial Systems MARANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		11 11	e XVIII	Subprovider -	PPS	
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 442, 837		0	1. 00
2.00	Interim payments payable on individual bills, either)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER				0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER					3. 01
3. 02						3. 02
3. 04						3. 04
3. 05					0	3. 05
0.00	Provider to Program				J	0.00
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3.51			l c)	0	3. 51
3.52			l c)	0	3. 52
3.53			[c)	0	3. 53
3.54			[c)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 442, 837		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		ı			5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C)	0	5. 01
5. 02					0	5. 02
5.03			l c)	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			0)	0	5. 51
5. 52			[C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
4 01	the cost report. (1) SETTLEMENT TO PROVIDER				o	4 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		26, 483			6. 01 6. 02
7.00	Total Medicare program liability (see instructions)		3, 416, 354			7. 00
7.00	Total modicale program trability (see Histructions)		3,410,334	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		1		

llool +b	Financial Customs MADION CENEDAL III	ACDI TAI	la lio	of Form CMC 1	DEED 10
	Financial Systems MARION GENERAL HO ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150011	Peri od: From 07/01/2013 To 06/30/2014		pared:
		Title XVIII	Hospi tal	PPS	то р
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst S-		ne 14	4, 887	1. 00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8	-12		8, 969	2. 00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			2, 176	3. 00
4. 00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		18, 667	4. 00
5. 00	Total hospital charges from Wkst C, Part I, column 8 line 200			358, 948, 474	5. 00
6.00	Total hospital charity care charges from Wkst S-10, column 3 li			65, 613, 193	
7. 00	CAH only - The reasonable cost incurred for the purchase of cer Part I line 168	tified HIT technology	Worksheet S-2,	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			2, 007, 397	8. 00
9.00	Sequestration adjustment amount (see instructions)			40, 148	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		1, 967, 249	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 483, 199	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	e 31) (see instruction	s)	484, 050	32.00
				Overri des	
				1.00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0	108. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	
		From 07/01/2013 Part III
	Component CCN: 15T011	To 06/30/2014 Date/Time Prepared:

11/20/2014 2: 46 pm Subprovi der -I RF Title XVIII

		Prior to 10/01	On/After 10/01	
		1. 00	1. 01	
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)	815, 687	2, 647, 734	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0186		2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	20, 147	45, 011	3. 00
4.00	Outlier Payments	15, 017		4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period	0.00		5. 00
	ending on or prior to November 15, 2004 (see instructions)			
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were	0.00		5. 01
	displaced by program or hospital closure, that would not be counted without a			
	temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			
6.00	New Teaching program adjustment. (see instructions)	0.00		6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth	0.00		7. 00
0.00	period of a "new teaching program". (see inst.)	0.00		0.00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth	0.00		8. 00
9. 00	period of a "new teaching program". (see inst.)	0.00		9. 00
10.00	Intern and resident count for IRF PPS medical education adjustment (see instructions) Average Daily Census (see instructions)	7. 819178		10. 00
11. 00		0.000000	0. 000000	11. 00
12.00	, , ,	0.000000	0.000000	12. 00
13. 00	3 3	3, 543, 596	U	13. 00
14. 00		3, 343, 370		14. 00
15. 00		O O		15. 00
16. 00		0		16. 00
17. 00	3	3, 543, 596		17. 00
18. 00		0, 545, 570		18. 00
19. 00	. 3 1.3. 1.3.	3, 543, 596		19. 00
20. 00		49, 152		20. 00
21. 00		3, 494, 444		21. 00
22. 00	·	8, 368		22. 00
23. 00		3, 486, 076		23. 00
24. 00		0		24. 00
25. 00		0		25. 00
26, 00	, ,	0		26. 00
27. 00	3	3, 486, 076		27. 00
28. 00	,	0		28. 00
29. 00		0		29. 00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		31.00
31. 99	Recovery of Accelerated Depreciation	0		31. 99
32.00	Total amount payable to the provider (see instructions)	3, 486, 076		32.00
32. 01	Sequestration adjustment (see instructions)	69, 722		32. 01
33.00	Interim payments	3, 442, 837		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	-26, 483		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	102, 568		36.00
	chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR			
50.00	3	15, 017		50.00
51.00	,	0		51.00
	The rate used to calculate the Time Value of Money	0.00		52. 00
53. 00	Time Value of Money (see instructions)	0		53. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared:

		1	o 06/30/2014	Date/Time Pre 11/20/2014 2:	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		3, 554, 805		1.00
2.00	Medical and other services		7, 22 1, 22 2	0	1
3. 00	Organ acquisition (certified transplant centers only)		0	_	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		3, 554, 805	0	1
5. 00	Inpatient primary payer payments		0	_	5. 00
6. 00	Outpatient primary payer payments			0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		3, 554, 805	Ō	1
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				1
8. 00	Routine service charges		2, 848, 578		8.00
9. 00	Ancillary service charges		6, 137, 259	0	1
10. 00	Organ acquisition charges, net of revenue		0	_	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		8, 985, 837	0	1
	CUSTOMARY CHARGES				1
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	g-		_	
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	0.000000	15. 00
16.00	Total customary charges (see instructions)		8, 985, 837	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	5, 431, 032	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	3, 554, 805	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	rs.		
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00			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	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		3, 554, 805	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)		3, 554, 805	0	
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
35. 00			0		35. 00
36. 00		33)	3, 554, 805	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
38. 00	Subtotal (line 36 ± line 37)		3, 554, 805	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		3, 554, 805	0	1
41. 00	Interim payments		5, 477, 833	0	
42.00	Balance due provider/program (line 40 minus line 41)		-1, 923, 028	0	1
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				1
100.00	OVERRI DES				100 00
109.00	Override Ancillary service charges (line 9)		0	0	109. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	Peri od: From 07/01/2013	Worksheet E-3 Part VII
	Component CCN: 15T011	To 06/30/2014	Date/Time Prepared: 11/20/2014 2:46 pm
	Title XIX	Subprovi der -	Cost

PART VIII - CALCULATION OF RETINSURSENSITY - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			litle XIX	Subprovi der - I RF	Cost	
PART VII - CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					Outpatient	
PART VI					<u> </u>	
COMPUTATION OF NET COST OF COURSED SERVICES 1.00 Injust of the throught of 159/M/F/ services 1.00 1.00 Injust of the throught of 159/M/F/ services 1.00 2.00 3.00 07gan acquisition (certified transplant centers only) 2.00 3.00 07gan acquisition (certified transplant centers only) 3.00 07gan acquisition (certified transplant centers only) 3.00 07gan acquisition (certified transplant centers only) 0.10 0.00 0.		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX			
2.00 Medical and other services 0 2.00 3.00 0.00 acquisition (certified transplant centers only) 0 3.00 3.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00						
3.00 Organ acquisition (certified transplant centers only)	1.00	Inpatient hospital/SNF/NF services		161, 399		1.00
Subtotal (sum of lines 1, 2 and 3)					0	1
Inpatient primary payer payments				0	ļ	1
0.00 0.00				161, 399	0	1
2.00 Subtotal (line 4 less sum of lines 5 and 6) 7,00				0	_ !	
COMPUTATION OF LESSER OF COST OR CHARGES				4/4 000		
Reasonable Charges	7. 00			161, 399	0	7.00
Rout Rout Reservice charges 130, 601 8, 80 0 10, 00 0 0 0 0 0 0 0 0						-
9,00 Ancillary service charges 157,991 0 9.00	9 00			120 441		0 00
10.00 Organ acquisition charges, net of revenue 0 10.00 11.00 10.01 10.0		1			0	1
11.00 Incentive from target amount computation 288,652 0 12.00 CUSTOMARY CHARGES				137, 441	U ₁	
12.00 Total reasonable charges (sum of lines 8 through 11) 288,652 0 12.00					ļ	1
CUSTOMARY CHARGES 13.00 10.00 13.00				288 652	0	1
13.00 Amount actually collected from patients	12.00			200,002	0	12.00
14.00 Amounts that would have been realized from patients Iable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00	13. 00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00
15.00	14. 00	Amounts that would have been realized from patients liable for p	3	О	0	14. 00
16. 00 Total customary charges (see instructions) 288, 652 0 16. 00 17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 127, 253 0 17. 00 17.	45.00		CFR §413. 13(e)		0.00000	45.00
17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 127, 253 0 17. 00		,				1
Iine 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 18.00 16) (see instructions) 0 0 10,00 10 10 10 10 1			if line 1/ evenede		-	
18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 0 18. 00 16) (see instructions) 0 0 19. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18. 00 19. 0	17.00		II Title to exceeds	127, 253	U	17.00
19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 20.00 20.50 20.50 20.00 2	18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 161,399 0 21.00	10.00				0	10.00
21.00 Cost of covered services (enter the lesser of line 4 or line 16) 161, 399 0 21.00			etions)	0	-	1
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.		, , , , , , , , , , , , , , , , , , , ,	•	161 300		1
22. 00 Other than outlier payments 0 0 22. 00	21.00			·	- U	21.00
23. 00	22. 00		p. 0.000 101 110 p. 011 00		0	22.00
24. 00 Program capital payments 25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 37. 00 Utilization review 38. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 Interim payments 41. 00 Direct graduate medical education payments (from Wkst. E-4) 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115. 2 OVERRIDES		, ,		0		1
26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 36.00 Utilization review 37.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Linterim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2 DVERRI DES	24.00			0	ļ	24. 00
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 1 itles V or XIX (sum of lines 21 and 27) 161, 399 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 161, 399 0 31. 00 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 0 32. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 161, 399 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 161, 399 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Interim payments 187, 961 0 41. 00 41. 00 Interim payments (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115. 2 OVERRIDES	25.00	Capital exception payments (see instructions)		0	ļ	25. 00
28. 00 Customary charges (title V or XIX PPS covered services only) 7 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Deductibles 30. 00 Deductibles 30. 00 Ion surance 30.	26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
Titles V or XIX (sum of lines 21 and 27)	27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 161, 399 0 31.00 0 32.00 0 32.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 34.00 0 0 34.00 0 0 34.00 0 0 35.00 0 0 35.00 0 0 35.00 0 0 0 0 0 0 0 0 0	28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 32.00 Deductibles 32.00 Allowable bad debts (see instructions) 33.00 Utilization review 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 40.00 Interim payments 42.00 Bal ance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, Other in the sum of lines 20 and 30	29. 00	Titles V or XIX (sum of lines 21 and 27)		161, 399	0	29. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coi nsurance 33.00 Coi nsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, Chapter 1, §115.2 OVERRI DES					_	
32.00 Deductibles 0 32.00 33.00 Coinsurance 0 0 32.00 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 161,399 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 161,399 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 161,399 0 40.00 41.00 Interim payments 187,961 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -26,562 0 42.00 Chapter 1, §115.2 OVERRI DES				0		1
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 161,399 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 161,399 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 39.00 Total amount payable to the provider (sum of lines 38 and 39) 161,399 0 40.00 41.00 Interim payments 187,961 0 41.00 42.00 Bal ance due provider/program (line 40 minus line 41) -26,562 0 42.00 Chapter 1, §115.2 OVERRI DES				161, 399	-	
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 161,399 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 161,399 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 161,399 0 40.00 41.00 Interim payments 187,961 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -26,562 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0		1
35. 00 Utilization review 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 161, 399 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 161, 399 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 161, 399 0 40. 00 41. 00 Interim payments 187, 961 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) -26, 562 0 42. 00 43. 00 Chapter 1, §115. 2 OVERRI DES				0	-	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, OVERRIDES 161, 399 0 36.00 37.00 38.00 39.00 161, 399 0 40.00 161, 399 0 40.00 161, 399 0 40.00 161, 399 0 40.00 41.00 42.00 43.00		1		0	U	1
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 161, 399 0 38.00 39.00 161, 399 0 40.00 11nterim payments 187, 961 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, Ochapter 1, §115.2 OVERRIDES			22)	161 200	0	1
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, Chapter 1, §115.2 OVERRIDES 161, 399 0 38.00 39.00 40.00 41.00 41.00 42.00 43.00 42.00			13)	101, 377		1
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2 OVERRIDES 39.00 40.00 41.00 41.00 42.00 43.00				161 300		
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, Chapter 1, §115.2 OVERRI DES 161, 399 187, 961 0 41.00 42.00 43.00					١	
41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, Chapter 1, §115.2 OVERRIDES 187, 961 -26, 562 0 42.00 43.00				161, 399	0	
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00 Chapter 1, §115.2 OVERRIDES		, , , , , , , , , , , , , , , , , , , ,				
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00 chapter 1, §115.2 OVERRIDES		1				
OVERRI DES	43.00		with CMS Pub 15-2,	0	0	
						1
109.00 0verride Ancillary service charges (line 9) 0 109.00						
	109.00	Override Ancillary service charges (line 9)		0	0	109. 00

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

				0 06/30/2014	Date/Time Pre 11/20/2014 2:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	TO PIII
			Purpose Fund			
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	25, 440, 006) O	0	1.00
2. 00	Temporary investments	2, 170, 235	•		0	
3.00	Notes recei vabl e	0	C	0	0	3. 00
4.00	Accounts receivable	41, 561, 996		0	0	
5.00	Other recei vable	2, 059, 343			0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-23, 898, 196 1, 696, 833		1 1	0	
8.00	Prepai d expenses	1, 431, 172			0	1
9. 00	Other current assets	1, 111, 087		0	0	
10.00	Due from other funds	0	C	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	51, 572, 476	(0	0	11. 00
10.00	FI XED ASSETS	4 422 240			0	12.00
12. 00 13. 00	Land Land improvements	4, 422, 248 3, 262, 659			0	
14. 00	Accumulated depreciation	-1, 719, 718			0	
15. 00	Bui I di ngs	108, 317, 369			0	
16. 00	Accumulated depreciation	-62, 998, 552	C	0	0	16. 00
17. 00	Leasehold improvements	859, 249			0	
18.00	Accumulated depreciation	-655, 716 1, 098, 638		0	0	
19. 00 20. 00	Fixed equipment Accumulated depreciation	-1, 016, 823			0	
21. 00	Automobiles and trucks	952, 202			0	
22. 00	Accumul ated depreciation	-702, 440		o	0	1
23. 00	Major movable equipment	73, 968, 615	•	0	0	
24. 00	Accumulated depreciation	-55, 644, 471	(0	0	1
25. 00 26. 00	Minor equipment depreciable	0			0	
26.00	Accumulated depreciation HIT designated Assets	0			0	
28. 00	Accumul ated depreciation	Ö		o o	0	
29. 00	Mi nor equi pment-nondepreci abl e	6, 780, 665	(0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	76, 923, 925	(0	0	30.00
24 00	OTHER ASSETS	102 201 110	10.455		0	21 00
31. 00 32. 00	Investments Deposits on Leases	183, 301, 110	10, 155		0	
33. 00	Due from owners/officers	0			0	
34. 00	Other assets	9, 593, 522	d	O	0	
35. 00	Total other assets (sum of lines 31-34)	192, 894, 632	10, 155		0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	321, 391, 033	10, 155	0	0	36. 00
37. 00	CURRENT LIABILITIES	4 014 074			0	27.00
38.00	Accounts payable Salaries, wages, and fees payable	4, 814, 874 8, 019, 840		0	0	
39. 00	Payrol I taxes payable	0,017,040		o o	0	1
40.00	Notes and Loans payable (short term)	O	C	0	0	1
41. 00	Deferred income	0	C	0	0	
42. 00	Accel erated payments	0				42.00
43.00	Due to other funds Other current liabilities	2, 927, 919			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	15, 762, 633		1	0	
10.00	LONG TERM LIABILITIES	10/102/000		·1		10.00
46.00	Mortgage payable	0	C	0	0	1
47. 00	Notes payable	0	C	0	0	
48. 00	Unsecured Loans	70.005.000		0	0	1
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	70, 885, 828 70, 885, 828			0	1
51. 00	Total liabilites (sum of lines 45 and 50)	86, 648, 461			0	1
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	234, 742, 572				52. 00
53. 00	Specific purpose fund		10, 155			53. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	1
	replacement, and expansion					
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	234, 742, 572 321, 391, 033			0	
00.00	[59]	321,371,033	10, 155	,		00.00
		1	1	1	ı	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					То	06/30/2014	Date/Time Prep 11/20/2014 2:4	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	•
		1.00	2.00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0	211, 414, 063 23, 328, 509 234, 742, 572		0 0 0 0 0	10, 155 10, 155	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 18. 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	0 0 0 0 0 0	0 234, 742, 572 0		0 0 0 0 0	0 10, 155	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	sheet (line 11 minus line 18)		234, 742, 572			10, 155		19. 00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period 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 18. 00 19. 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			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

			11	0 06/30/2014	Date/IIme Prep 11/20/2014 2:4	
	Cost Center Description		Inpati ent	Outpati ent	Total	
	· · · · · · · · · · · · · · · · · · ·		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•		•		
	General Inpatient Routine Services					
1.00	Hospi tal		19, 014, 192		19, 014, 192	1.00
2.00	SUBPROVI DER - I PF		3, 641, 022		3, 641, 022	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER		0		0	4.00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		_		-	7. 00
8.00	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, 655, 214		22, 655, 214	10.00
10.00	Intensive Care Type Inpatient Hospital Services		22,000,211		22,000,211	10.00
11. 00	INTENSIVE CARE UNIT	T	7, 862, 166		7, 862, 166	11. 00
12. 00	CORONARY CARE UNIT		7,002,100		7,002,100	12.00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nos	7, 862, 166		7, 862, 166	16. 00
16.00	111-15)	iles	7, 002, 100		7, 002, 100	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		30, 517, 380		30, 517, 380	17. 00
18. 00	Ancillary services		77, 265, 594		77, 265, 594	18. 00
19. 00	Outpatient services		77, 205, 594 0	250, 911, 755	250, 911, 755	19. 00
	RURAL HEALTH CLINIC		0	250, 911, 755	250, 911, 755	
20. 00 21. 00			0	0	0	20.00
	FEDERALLY QUALIFIED HEALTH CENTER		U	U	U	21. 00
22. 00	HOME HEALTH AGENCY		0	4 000 007	4 000 007	22. 00
23. 00	AMBULANCE SERVICES		U	4, 028, 087	4, 028, 087	23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE			07 5/0 005	07 5/0 005	26. 00
27. 00	PHYSI CI AN PRACTI CE		0		27, 568, 235	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	WKST.	107, 782, 974	282, 508, 077	390, 291, 051	28. 00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES			151 524 071		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		0	151, 524, 971		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0	_		35. 00
36. 00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40. 00			0			40.00
41. 00			0			41.00
42. 00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		151, 524, 971		43.00
	to Wkst. G-3, line 4)			I		

Heal th	Financial Systems MARION	GENERAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150011	Peri od:	Worksheet G-3	
			From 07/01/2013 To 06/30/2014	Date/Time Prep 11/20/2014 2:4	
				11/20/2014 2.2	40 pili
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column	n 3, line 28)	,	390, 291, 051	1. 00
2.00	Less contractual allowances and discounts on patients			241, 354, 533	
3.00	Net patient revenues (line 1 minus line 2)			148, 936, 518	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part I	I, line 43)		151, 524, 971	
5.00	Net income from service to patients (line 3 minus line			-2, 588, 453	5. 00
	OTHER I NCOME	,			
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			21, 311, 746	7. 00
8.00	Revenues from telephone and other miscellaneous commu	nication services		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	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to	other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and cantee	n		0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE-ELIMINATING ENTRY			4, 479, 373	24.00
25.00	Total other income (sum of lines 6-24)			25, 791, 119	25. 00
26.00	Total (line 5 plus line 25)			23, 202, 666	26.00
27. 00	BAD DEBT EXPENSE			-125, 843	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			-125, 843	
29. 00	Net income (or loss) for the period (line 26 minus li	ne 28)		23, 328, 509	29. 00

	ATION OF CAPITAL PAYMENT	Provi der CCN: 150011	Peri od: From 07/01/2013 To 06/30/2014	Worksheet L Parts I-III Date/Time Pre 11/20/2014 2:4	
		Title XVIII	Hospi tal	PPS	40 L
	DART I FILLY PROCEETIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				1
00	Capital DRG other than outlier			1, 097, 818	1
01	Model 4 BPCI Capital DRG other than outlier			1, 077, 010	1
00	Capital DRG outlier payments			8. 990	
01	Model 4 BPCI Capital DRG outlier payments			0	1
00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	51.56	3
00	Number of interns & residents (see instructions)			0.00	4
00	Indirect medical education percentage (see instructions)			0.00	5
00	Indirect medical education adjustment (multiply line 5 by the			0	
00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	,	, part A line	0. 00	
00	Percentage of Medicaid patient days to total days (see instru	ictions)		0.00	
00	Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions	.)		0. 00 0. 00	
. 00	Disproportionate share adjustment (line 10 times the sum of l	,		0.00	11
. 00	Total prospective capital payments (sum of lines 1, 1.01, 2,			1, 106, 808	
. 00	Total prospective capital payments (Sum of Times 1, 1.01, 2,	2.01, 0 and 11)		1, 100, 000	12
	DART LL DAVMENT UNDER REACONABLE COST			1. 00	
00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			0	
00	Applicable exception percentage (see instructions)			0.00	
00 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	octructions)		0 0. 00	
00	Adjustment to capital minimum payment level for extraordinary	,	· Lino 6)	0.00	
00	Capital minimum payment level (line 5 plus line 7)	Circuistances (Time 2 x	. Title 0)	0	
00	Current year capital payments (from Part I, line 12, as appli	cable)		0	
. 00	Current year comparison of capital minimum payment level to c		less line 9)	0	
00	Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)			0	11
. 00	Net comparison of capital minimum payment level to capital pa	•	,	0	
00	Current year exception payment (if line 12 is positive, enter			0	
. 00	Carryover of accumulated capital minimum payment level over c	capital payment for the f	following period	0	14
. 00	(if line 12 is negative, enter the amount on this line)				
3. 00 1. 00 5. 00 5. 00		structions)		0	