Heal th Financia	al Systems	MARION GENERAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
	required by law (42 USC 1395g; since the beginning of the cost				FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	Worksheet S Parts I-III Date/Time Prepared: 11/23/2016 9:25 am				
PART I - COST	REPORT STATUS			·	
Provi der use only	1. [X] Electronically filed on 2. [] Manually submitted costs 3. [0] If this is an amended 4. [F] Medicare Utilization.	t report report enter the number of	fimes the provide	Date: er resubmitted this co	Time: ost report
Contractor use only	5. [1]Cost Report Status 6 (1) As Submitted 7 (2) Settled without Audit 8 (3) Settled with Audit 9 (4) Reopened	. Contractor No.	this Provider CCN		

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARION GENERAL HOSPITAL (150011) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	Y\/			
	C+ C+ D -+	T: ±1 = \/				T: +1 - VIV	
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-519, 514	60, 053	-69, 285	-2, 268	1.00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	-15, 072	0		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	-534, 586	60, 053	-69, 285	-2, 268	200.00

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

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	1	Provi	der CCN	N: 150011	Period: From 07/01, To 06/30,		Workshe Part I Date/Ti	me Pre	
	1.00	2.0	0		3. 00			4. 00	11/23/2	2016 9:	25 am
1. 00	Hospital and Hospital Health Care Co Street: 441 WABASH AVENUE	mpl ex Address: PO Box:									1. 00
2. 00	City: MARION	State: IN	Zi	p Code	e: 46952	- Coun	ty: GRANT				2. 00
		Component Nam		CCN	CBSA	Provi dei			nt Syst		
			Nu	ımber	Number	Type	Certi fi ed	V	, 0, or		
		1.00	2	. 00	3. 00	4. 00	5. 00	6. 00			
3. 00	Hospital and Hospital-Based Componen Hospital	t Identification: MARION GENERAL HOS	DITΔI 15	0011	99915	1	07/01/1966	N	P	0	3. 00
4. 00	Subprovi der - IPF	MARTON GENERAL 1103	TIAL 13		77713	'	0770171700		'		4. 00
5.00	Subprovi der - IRF	MARION GENERAL HOS	PITAL 15	T011	99915	5	07/01/2005	N	P	0	5. 00
6. 00	Subprovider - (Other)	REHAB									6. 00
7.00	Swing Beds - SNF										7. 00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF										8. 00 9. 00
	Hospital -Based NF										10.00
	Hospi tal -Based OLTC			İ							11. 00
	Hospi tal -Based HHA			1							12. 00
	Separatel y Certi fi ed ASC Hospi tal -Based Hospi ce										13. 00 14. 00
	Hospital-Based Health Clinic - RHC										15. 00
	Hospital -Based Health Clinic - FQHC]							16. 00
	Hospital -Based (CMHC) I										17. 00
18. 00 19. 00	Renal Dialysis Other										18. 00 19. 00
19.00	other						From		To	:	19.00
							1.00		2. (
20.00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						07/01/2	:015	06/30/	/2016	20. 00 21. 00
21.00	Inpatient PPS Information										21.00
22. 00	Does this facility qualify and is it								N		22. 00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil	-									
	amendment hospital?) In column 2, en				2. 100 (C,) (2) (FI CKI					
22. 01	Did this hospital receive interim un	compensated care pa	ayments fo	or this			N		Υ		22. 01
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	opor tring porrou co.	our rrig o	0. 4							
22. 02	Is this a newly merged hospital that						N		N		22. 02
	determined at cost report settlement or "N" for no, for the portion of the						'S				
	in column 2, "Y" for yes or "N" for						n				
	or after October 1.										
22. 03	Did this hospital receive a geograph								N		22. 03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column	2, "Y" for yes or	"N" for no	o for	the por	tion of th	e				
	cost reporting period occurring on o										
	hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,			untea	in acco	ruance wit	n				
23. 00	Which method is used to determine Me			or 25/	bel ow?	In column	.	3	N		23. 00
	1, enter 1 if date of admission, 2 i						.				
	method of identifying the days in the used in the prior cost reporting per										
	, , , , , , , , , , , , , , , , , , ,		n-State	In-St	tate	Out-of	Out-of !	Medi ca		ther	
			Medicaid	Medic eligi		State		HMO dag	·	li cai d	
		۲	aid days	unpa			Medicaid eligible			lays	
				day			unpai d				
04.55	lie iii		1.00	2. 0		3. 00	4. 00	5. 00		. 00	0.1 -:
24. 00	If this provider is an IPPS hospital in-state Medicaid paid days in column	•	433	ĺ (1, 841	0	0	2,	808	0	24. 00
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c	olumn 3,									
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in										
25. 00	If this provider is an IRF, enter th		0		157	0	О		35		25. 00
	Medicaid paid days in column 1, the	i n-state									
	Medicaid eligible unpaid days in col out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day										

HOSPI TA	Financial Systems AL AND HOSPITAL HEALTH CARE COMPL			L HOSPI TAL Provi der (eri od:	Worksheet S-2	
					To	om 07/01/2015 06/30/2016	Part I Date/Time Pre 11/23/2016 9:	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	25 4111
51. 06	Enter the amount of ACA §5503 aw	ard that is boing	1.00	2. 00	3. 00	4. 00	5. 00	61. 0
	used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			01.0
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2. 00	3. 00	4. 00	
	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instrucolumn 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0.00	61.1
61. 20	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61. 2
'	., <u>g</u>						1.00	
	ACA Provisions Affecting the Hea							
	your hospital received HRSA PCRE funding (see instructions)							62.0
	during in this cost reporting pe	riod of HRSA THC prog	ıram. (s	<u>ee instruction</u>		your nospi tai	0.00	02.0
	Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eri od? Enter	N	63. 00
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , ,			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te			
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovi d	der SettingsT	1.00 This base year	2.00 is your cost r	3.00 reporting	
64. 00	period that begins on or after J Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit per of unweighted non tations occurring in number of unweighted ur hospital. Enter in	y train i-primar all non I non-pr i column	ed residents y care provider imary care 3 the ratio	0. 00	0.00	0. 000000	64. 0
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	,
	-	1.00		2. 00	Si te 3. 00	4. 00	5. 00	-
	Enter in column 1, if line 63 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				0.00			65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	RAL HOSPITAL		۱r	ιLieu	u of Form CMS	-2552-10
	Provi der		eriod: fom 07/01/ o 06/30/		Worksheet S- Part I Date/Time Pr	epared:
			V		11/23/2016 9 XI X	7. 23 alli
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for years.			1. 00 0. 00 N		2. 00 0. 00 N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	oplicable colum	n.	0. 00		0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (0 106.00 of this facility qualifies as a CAH, has it elected the all		hod of payment	N N			105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	nn 1. (see inst	ructions) If	N			107. 00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00		Respi ratory 4.00	<u>'</u>
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N		N N	109. 00
440.00		(440			1. 00	440.00
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo) For		N	110. 00
				1. 00	2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2	or "N" for no i 2. If column 2	n column 1. If is "E", enter i	column 1	N	0	115. 00
3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	ent for long te	rm care (includ	es			
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			N" for	Y Y		116. 00 117. 00
118.00 is the mal practice insurance a claims-made or occurrence po	olicy? Enter 1	if the policy i	s	1		118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	5	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 946, 761	2. 00		3. 00	
				0		0 118. 01
		,,		0	2.00	0 118. 01
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche		than the	1. 00 N	0	2.00	118. 02
	edule listing c d Harmless pro n column 1, "Y qualifies for t	than the ost centers vision in ACA " for yes or he Outpatient	1. 00	0	2. 00 Y	
Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implications.	edule listing c d Harmless pro n column 1, "Y qualifies for t ents? (see inst	than the ost centers vision in ACA " for yes or he Outpatient ructions)	1. 00 N	O		118. 02
Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device ? Enter "Y" for	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	1. 00 N	O		118. 02 119. 00 120. 00
Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device ? Enter "Y" for the Worksheet A	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	1. 00 N	O		118. 02 119. 00 120. 00
Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device ? Enter "Y" for the Worksheet A for yes and "N"	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	1.00 N Y	O		118. 02 119. 00 120. 00 121. 00
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Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implication patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified	d Harmless pro n column 1, "Y qualifies for tents? (see inst antable device? Enter "Y" for the Worksheet A for yes and "N" enter the certif 2. ter the certif 2.	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	1.00 N Y	0		118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00
Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device ? Enter "Y" for the Worksheet A for yes and "N" enter the certif 2. nter the certif 2. ter the certifi	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date in	1.00 N Y	0		118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00
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ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	MARION GENERA X IDENTIFICATION DATA	Provider C	CN: 15001	From O		u of Form CMS Worksheet S- Part I Date/Time Pr	2 repared:
						11/23/2016 9): 25 am
					1. 00	2. 00	
33.00 If this is a Medicare certified ot			cation dat	:e			133. 00
in column 1 and termination date,							124 0
34.00 If this is an organ procurement or and termination date, if applicabl		ne upu number ir	1 COLUMN				134. 00
All Providers	e, TH Corumn 2.						
40.00 Are there any related organization	or home office costs as	defined in CMS F	Pub. 15-1,		N		140. 00
chapter 10? Enter "Y" for yes or "				sts			
are claimed, enter in column 2 the	home office chain number. 2.0		ons)		3. 00		
If this facility is part of a chai			nh 143 th	name and		of the	
home office and enter the home off				o riallic ario	a ddui css	or the	
41. 00 Name:	Contractor's Name:		Contra	ictor's Nu	ımber:		141. 0
42.00 Street:	PO Box:						142. 0
43. 00 Ci ty:	State:		Zi p Co	ide:			143. 0
						1.00	_
44.00 Are provider based physicians' cos	sts included in Worksheet /	١?				1.00 Y	144. 0
, . ,							
					1. 00	2.00	
45.00 If costs for renal services are cl	aimed on Wkst. A, line 74,	are the costs	for		N		145. 0
inpatient services only? Enter "Y" no, does the dialysis facility inc				5			
period? Enter "Y" for yes or "N"		TOT LITTS COST I	epoi triig				
46.00 Has the cost allocation methodolog		usly filed cost	report?		N		146. 0
Enter "Y" for yes or "N" for no in	column 1. (See CMS Pub.			lf			
yes, enter the approval date (mm/d	d/yyyy) in column 2.						
						1.00	
47.00 Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for r	10			1.00 N	147. 0
48.00 Was there a change in the order of						N N	148. 00
49.00 Was there a change to the simplifi				or no.		N	149. 0
		Part A	Part E	3 T	itle V	Title XIX	
D thi- f!!!tt-!!		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "							
55. 00 Hospi tal	TO THE TOT GLOTT COMPONE	N N	N		N	N	155. 0
56.00 Subprovi der - IPF		N	N		N	N	156. 0
57.00 Subprovider - IRF		N	N		N	N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF 60. 00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 0 160. 0
61. OO CMHC		IN	N		N	N	161. 0
01. 00 OM/10							101.0
						1.00	
Mul ti campus							
65.00 Is this hospital part of a Multica	mpus hospital that has one	e or more campus	ses in dit	ferent CE	BSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3.00	4. 00	5. 00	_
66.00 If line 165 is yes, for each							00 166. 0
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 (see instructions)							
cordini 5 (see riistructrons)							
cordini 5 (see mstructrons)							
						1.00	
Health Information Technology (HII							1/7.0
Health Information Technology (HIT 67.00 s this provider a meaningful user	under §1886(n)? Enter "\	(" for yes or "N	√ for no.		- the	1. 00 Y	167. 0
Health Information Technology (HIT 67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10	under §1886(n)? Enter "Y O5 is "Y") and is a meaning	/" for yes or "N gful user (line	√ for no.		the		167. 0 0168. 0
Health Information Technology (HIT 67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 if this provider is a CAH and is n	under §1886(n)? Enter "\ 5 is "Y") and is a meaning HT assets (see instruction not a meaningful user, does	(" for yes or "N gful user (line ns) s this provider	l" for no. 167 is "\ qualify 1	("), enter For a hard			
Health Information Technology (HIT 67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter "\ 5 is "Y") and is a meaning HT assets (see instruction not a meaningful user, does Enter "Y" for yes or "N"	(" for yes or "N gful user (line ns) s this provider for no. (see ir	Tor no. 167 is "\ qualify 1 nstruction	("), enter For a harc ns)	dshi p	Y	0168.0

Health Financial Systems	MARION GENERAL HO	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provi der CCN: 150011	Peri od:	Worksheet S-2		
			From 07/01/2015			
	To 06/30/2016					
			Begi nni ng	Endi ng		
			1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)	09/30/2015	170. 00				
				1.00		
171.00 f line 167 is "Y", does this provider Medicare cost plans reported on Wkst. (see instructions)	N	171. 00				

SPI TA	Financial Systems MARION GENERA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Period: From 07/01/2015	Worksheet S-2 Part II Date/Time Pre 11/23/2016 9:	epared:
				Y/N	Date	Eo am
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	r all dates in	the	
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N	T	1.0
00	reporting period? If yes, enter the date of the change in c			IN		1.0
	Topol tring portion. The yes, enter the date of the change the	101 dilli1 2. (300	Y/N	Date	V/I	
			1.00	2. 00	3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	ın 3, "V" for	N			2.00
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	Y			3.00
	Terationships: (see Thistructions)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.00
00	Are the cost report total expenses and total revenues diffe	rent from	N			5. 00
	those on the filed financial statements? If yes, submit rec	onciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If you is th	ne provider is	N		6.00
,,	the legal operator of the program?	11 yes, 15 ti	ic provider 13	14		0.00
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	S.		N		9.00
00	Was an approved Intern and Resident GME program initiated o	r renewed in t	the current	N		10.00
00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& Rin an Anr	roved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	a it iii ali App	71 0 4 0 4			11.00
•					Y/N	
					1.00	
	Bad Debts				1 ,	1.0.0
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	Y N	12.00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14. 00
00]	Did total beds available change from the prior cost reporti		yes, see insti t A Date		t B Date	15. 00
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
00	Was the cost report prepared using the PS&R 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	N		N		16.00
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	10/14/2016	Y	10/14/2016	17. 00
	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems MARION GENER	RAL HOSPITAL		In Lie	u of Form CM	S-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	Worksheet S Part II Date/Time F 11/23/2016	repared:		
		Descri	pti on	Y/N	Y/N			
		O)	1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
04.00	lui ii i	1.00	2. 00	3.00	4. 00	04.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS HO	OSPI TALS)					
22.00	Capital Related Cost	a instructions						
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost		22. 00 23. 00		
	reporting period? If yes, see instructions.			Ü				
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost re	eporting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	'If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	he cost reporti	ng period? I	f yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during th	ne cost reportino	g period? If	yes, submit		27. 00		
	copy. Interest Expense							
28. 00								
29. 00	Did the provider have a funded depreciation account and/or		bt Service R	Reserve Fund)		29. 00		
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes	s, see		30. 00		
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without i instructions.</pre>	ssuance of new o	debt? If yes	s, see		31. 00		
	Purchased Services							
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr	ervices furnished	d through co	ntractual		32. 00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		g to competi	tive bidding? If		33. 00		
	Provi der-Based Physi ci ans							
34.00	Are services furnished at the provider facility under an a	rrangement with	provi der-ba	sed physicians?		34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	disting agreemen	ts with the	provi der-based		35. 00		
	physicians during the cost reporting period? If yes, see i			·				
				Y/N	Date			
	Homo Offi co Costs			1.00	2. 00			
36. 00	Home Office Costs 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 If yes, see instructions.	prepared by the I	home office?	•		37. 00		
38. 00	If line 36 is yes , was the fiscal year end of the home of			-		38. 00		
39. 00	'			i,		39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00		
	That detrois.		20		00			
	Cost Report Preparer Contact Information	1. (30	2.	00			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LLC	2			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7946		TSEVERS@BLUEAN	DCO COM	43. 00		
45.00	report preparer in columns 1 and 2, respectively.	317-713-7740		JOEVENSEDEUEAN	DOO. COM	43.00		

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTI ONNAI RE	Provi der	CCN: 150011	Peri od:	Worksheet S-2	
				From 07/01/2015 To 06/30/2016	Part II Date/Time Pre	narod:
				10 00/30/2016	11/23/2016 9:	
		3.	00			
Cost Report Preparer Contact Information	on					
41.00 Enter the first name, last name and the		ANAGER				41. 00
held by the cost report preparer in co	umns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the	cost report					42. 00
preparer.						
43.00 Enter the telephone number and email a						43. 00
report preparer in columns 1 and 2, res	specti vel y.					

Heal th	Financial Systems MARION GENERAL H	HOSPI TAL		Non-CMS HFS Wor	ksheet
HFS Su	pplemental Information	Provi der CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	11/23/2016 9:	pared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
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 column column 2 for Title XIX.		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.		Υ	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 inpatier		N 2	N	4. 00
5. 00	for outpatient. Does Title XIX follow Medicare (Title XVIII) for Critical Accereimbursed 101% of cost? Enter Y or N in column 1 for inpatien for outpatient.		2	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	Υ	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
	RHC				
8. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Title V and Y/N in column 2 for Title XIX.	er Y/N in column 1 for	N	N	8. 00

| Peri od: | Worksheet S-3 | From 07/01/2015 | Part I | To 06/30/2016 | Date/Time Prepared:
 Heal th Financial
 Systems
 MARION

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

					Τ	o 06/30/2016	Date/Time Prep 11/23/2016 9:2	
							I/P Days / 0/P	25 aiii
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
1 00		1.00		2.00	3.00	4.00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00		78	28, 548	0.00	0	1. 00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			7.0			0	6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)			78	28, 548	0.00	0	7. 00
8. 00	INTENSIVE CARE UNIT	31. 00		19	6, 954	0.00	o	8. 00
9. 00	CORONARY CARE UNIT	31.00		1 /	0, 75-	0.00	o l	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)			97	35, 502	0.00		14.00
15. 00	CAH visits						0	15. 00
16.00	SUBPROVIDER - I PF	40. 00		(1		0	16.00
17. 00	SUBPROVIDER - I RF	41. 00		18	6, 588		0	17.00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY	42. 00		C	ή		U	18. 00 19. 00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER			115				26. 25 27. 00
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days			115			0	28. 00
29. 00	Ambul ance Tri ps						U	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)			C)		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

| Peri od: | Worksheet S-3 | From 07/01/2015 | Part | To 06/30/2016 | Date/Time Prepared: |

				1	0 06/30/2016	11/23/2016 9:	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	6, 946	433	13, 720			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, 187	4, 649				2.00
3.00	HMO IPF Subprovider	2, 107	4, 04 7				3. 00
4. 00	HMO IRF Subprovider	177	192				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	177	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed SNI	o _l	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	6, 946	433	13, 720			7.00
7.00	beds) (see instructions)	0, 940	433	13, 720			7.00
8. 00	INTENSIVE CARE UNIT	1, 919	0	4, 309			8. 00
9. 00	CORONARY CARE UNIT	1, 717	o o	4, 307			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. 045			13.00
14. 00	Total (see instructions)	8, 865	433	20, 074		717. 86	
15. 00	CAH visits	0, 803	433	20, 074	0.00	/17.00	15. 00
16. 00	SUBPROVI DER - I PF	0	0	0	0.00	0.00	1
17. 00	SUBPROVIDER - I RF	2, 518	0	3, 086			1
18. 00	SUBPROVI DER	2,510	0	3,000	0.00	0.00	
19. 00	SKILLED NURSING FACILITY		Ů,	0	0.00	0.00	19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
21.00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)	0	0	0			24. 00
25. 00	CMHC - CMHC	o _l	Ů,	0			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	735. 70	
28. 00	Observation Bed Days		943	2, 872	0.00	733.70	28. 00
29. 00	Ambulance Trips	1, 348	743	2,012			29.00
30. 00	Employee discount days (see instruction)	1, 340		160			30.00
31. 00	Employee discount days (see l'istruction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 00 32. 01	Total ancillary labor & delivery room	ا	U	0			32.00
ა∠. ∪ I	outpatient days (see instructions)			0			32.01
33 00	LTCH non-covered days	0					33. 00
33.00	ETOTI HOTI-COVELEG Gays	١				I	1 33.00

				T	06/30/2016	Date/Time Pre	pared:
		Full Time		Disch	arges	11/23/2016 9: 2	25 am
		Equi val ents		5. 55.	a. goo		
	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		(2, 190	64	5, 198	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)			527	1, 211		2. 00
3.00	HMO IPF Subprovider			02.	0		3. 00
4. 00	HMO IRF Subprovider				13		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	0. 00		2 100		F 100	13. 00 14. 00
14. 00 15. 00	Total (see instructions) CAH visits	0.00	(2, 190	64	5, 198	14.00
16. 00	SUBPROVIDER - IPF	0. 00	(0	o	0	16. 00
17. 00	SUBPROVI DER - I RF	0.00	(1		275	17. 00
18. 00	SUBPROVI DER	0. 00	(1	ol ol	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	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00 29. 00	Observation Bed Days						28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Histruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 00
02.01	outpatient days (see instructions)						22.0.
33. 00	LTCH non-covered days						33. 00

| Peri od: | Worksheet S-3 | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Provider CCN: 150011

					T	06/30/2016	Date/Time Pre 11/23/2016 9:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	COI . 5)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							-
1. 00	Total salaries (see	200. 00	45, 875, 160	-170, 611	45, 704, 549	1, 829, 493. 29	24. 98	1.00
	instructions)		,,					
2. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2.00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
	B		05 050		05.050	005 00	450.00	
4. 00	Physician-Part A - Administrative		35, 250	0	35, 250	235. 00	150. 00	4.00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4. 01
5.00	Physician-Part B		0	0	0	0.00		
6. 00 7. 00	Non-physician-Part B Interns & residents (in an	21. 00	0	0	0	0. 00 0. 00		
7.00	approved program)	21.00				0.00	0.00	7.00
7. 01	Contracted interns and		0	0	0	0.00	0. 00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		0	0	0	0.00		
9.00	SNF	44. 00	7 (05 573	0	0 7 040 200	0.00		
10. 00	Excluded area salaries (see instructions)		7, 605, 572	334, 808	7, 940, 380	416, 906. 01	19. 05	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		530, 969	0	530, 969	7, 432. 05	71. 44	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0.00	0. 00	12.00
	management and other							
	management and administrative services							
13. 00	Contract Labor: Physician-Part		249, 600	О	249, 600	1, 664. 00	150. 00	13.00
14.00	A - Administrative					0.00	0.00	14.00
14. 00	Home office salaries & wage-related costs		U		0	0.00	0.00	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0.00	16. 00
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		14, 198, 259	0	14, 198, 259			17. 00
	instructions)		, . , 6, 26 ,		, ., ., ., .,			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		4, 262, 904	o	4, 262, 904			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
	В		_	_				
22. 00	Physician Part A - Administrative		1, 824	0	1, 824			22. 00
22. 01	Physician Part A - Teaching		0	О	0			22. 01
23. 00	Physician Part B		0	1	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
20.00	approved program)] 20.00
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	958, 351	59, 978	1, 018, 329	30, 790. 60	33. 07	26. 00
27. 00	Administrative & General	5. 00	8, 406, 215			· ·		
28. 00	Administrative & General under		3, 389, 624	0	3, 389, 624	18, 097. 00	187. 30	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	_	0	0.00	0. 00	29.00
30.00	Operation of Plant	7. 00	610, 857	-30, 566	580, 291	32, 641. 40		30.00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00	0. 00	31.00
32.00	Housekeepi ng	9. 00	1 5/1 207	0	_	0.00		
33. 00	Housekeeping under contract (see instructions)		1, 561, 297	0	1, 561, 297	109, 200. 00	14. 30	33. 00
34. 00	Di etary	10. 00	0	0	0	0.00		
35. 00	Di etary under contract (see instructions)		1, 331, 171	0	1, 331, 171	64, 666. 00	20. 59	35. 00
36. 00	Cafeteri a	11. 00	0	0	0	0.00	0.00	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		37. 00
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	1, 445, 173 132, 746			19, 849. 70 9, 472. 70		38. 00 39. 00
40. 00	1 ,	15. 00	2, 371, 296					40.00
	· -	. '					•	·

Health Financial Systems			MARION GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPI TAL	WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3		
						From 07/01/2015			
						To 06/30/2016			
							11/23/2016 9:	<u>25 am</u>	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5. 00	6. 00		
41. 00 Me	edical Records & Medical	16. 00	(0 0		0.00	0.00	41. 00	
Re	ecords Li brary								
42. 00 Sc	oci al Servi ce	17. 00	(0 0		0.00	0.00	42.00	
43. 00 0	ther General Service	18. 00	(0 (c		0.00	0.00	43. 00	

nearth Financial Systems			WARTON GENER	AL HUSPITAL		TH LIEU OF FOUR CW3-2002-10			
HOSPI	TAL WAGE INDEX INFORMATION			Provi der		Period: From 07/01/2015 To 06/30/2016			
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			·	(from	(col.2 ± col.	Salaries in	col . 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4. 00	5. 00	6. 00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		52, 157, 252	-170, 611	51, 986, 64	1 2, 021, 456. 29	25. 72	1. 00	
	instructions)								
2.00	Excluded area salaries (see		7, 605, 572	334, 808	7, 940, 38	0 416, 906. 01	19. 05	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		44, 551, 680	-505, 419	44, 046, 26	1 1, 604, 550. 28	27. 45	3. 00	
	minus line 2)								
4.00	Subtotal other wages & related		780, 569	0	780, 56	9, 096. 05	85. 81	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		14, 200, 083	0	14, 200, 08	3 0.00	32. 24	5. 00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		59, 532, 332	-505, 419	59, 026, 91	3 1, 613, 646. 33	36. 58	6.00	
7.00	Total overhead cost (see		20, 206, 730	-797, 831	19, 408, 89	9 672, 635. 50	28. 86	7. 00	
	1	ı	I	1		1	1		

instructions)

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL WAGE RELATED COSTS	Provider CCN: 150011	Peri od: Worksheet S-3		
		From 07/01/2015 Part IV		

	To 06/30/2016	Date/Time Pre 11/23/2016 9:	pared: 25 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 121, 032	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	6, 620, 445	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	219, 411	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)	8, 484, 264	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10. 00
11.00	Life Insurance (If employee is owner or beneficiary)	34, 343	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	445, 440	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	479, 776	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	3, 877, 249	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	8, 283	
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	324, 179	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	21, 614, 422	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE	151, 339	25. 00

Heal th	Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Peri od:	Worksheet S-3	
			rom 07/01/2015		
			o 06/30/2016	Date/Time Prep 11/23/2016 9:2	pared:
	Cost Center Description		Contract Labor		25 alli
	Cost Center Description				
		<u> </u>	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identi	fi cati on:			
1.00	Total facility's contract labor and benefit	cost	0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - IPF		0	0	3. 00
4.00	Subprovi der - I RF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
	lu i i b i oue		1		

8.00

9.00 10.00 11.00

12.00

13.00 14. 00 15.00 16.00 17.00 0 18.00

Hospi tal -Based SNF

12.00 Separately Certified ASC

Separately Certified ASC

13.00 Hospital-Based Hospice

14.00 Hospital-Based Health Clinic RHC

15.00 Hospital-Based Health Clinic FQHC

16.00 Hospital-Based-CMHC

17.00 Renal Dialysis

18.00 Other

9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based NF 11. 00 Hospi tal -Based HHA

8.00

	Hool +h	Financial Systems	MADLON CENEDAL HOS	CDI TAI		وناحا	u of Form CMC 1	NEED 10	
Uncompensated and indigent care cost computation			WARTON GENERAL HO		CCN: 150011				
	HUSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider	CCN: 150011		worksneet 5-10	J	
1.00							Date/Time Pre	oared:	
Discompensated and indigent care cost computation 0.00							11/23/2016 9:	25 am	
Discompensated and indigent care cost computation 0.00									
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.295628 1.00 Medicaid (See instructions for each line) 3.00 Old you receive DSI or supplemental payments from Medicaid? 3.00 Old you receive DSI or supplemental payments from Medicaid? 4.00 5.00 1.00 Irine 4 is "no", then enter DSH or supplemental payments from Medicaid? 4.00 5.00 6.00 Medicaid cost (line 1 times line 6) 5.00 1.00 Medicaid cost (line 1 times line 6) 42, 961, 464 6.00 42, 961, 464 6.00 6.00 Medicaid cost (line 1 times line 6) 12, 700, 612 7.00 Medicaid cost (line 1 times line 6) 12, 700, 612 7.00 Medicaid cost (line 1 times line 6) 12, 700, 612 7.00 12, 700, 612 7.00 Medicaid cost (line 1 times line 6) 12, 700, 612 7.00 12, 700, 612 7.00 12, 700, 612 7.00 12, 700, 612 7.00 12, 700, 612 7.00 12, 700, 612 7.00 12, 700 12, 700, 612 7.00 12, 700 12,							1. 00		
Medical d (see Instructions for each line) 2.00 Net revenue from Medicald 3.00					222		0.005400		
2.00 Net revenue from Medical d 6,255,560 2.00 4.00 1f line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicald? 4,001,464 6.00 6.00 1f line 4 is "no", then enter DSH or supplemental payments from Medicald? 4,001,464 6.00 6.00 Medicald charges 42,961,464 6.00 6.00 Medicald charges 42,961,464 6.00 6.00 10 10 10 10 10 10 10	1.00		202 column 3 divi	ded by II	ne 202 colum	า 8)	0. 295628	1.00	
3.00 3.00	2 00						/ 255 5/0	2 00	
4.00		1	Chica ibal mari				6, 255, 560		
1.1 1.1 1.2 1.5 "no", then enter DSH or supplemental payments from Medicald 4.2 9.41.464 6.00									
Modical dicharges		1			II OIII Medicali	11	0		
12,700,612 7.00 8.00 Modicald cost ((line 1 times line 6) 12,700,612 7.00 8.00 5 12,700,612 7.00 5 12,700,612 7.00 6,445,052 7.00 6,445,052 7.00 6,445,052 7.00		•	itai payillerits irolli	wedi cai u					
8.00		1							
State Children's Healt In Insurance Program (SCHIP) (see instructions for each line) 9.00		·	Medicaid program (L	ine 7 min	us sum of Li	nes 2 and 5 if			
State Children's Health Insurance Program (SCHIP) (see instructions for each line) 9,00 10,00 10,00 11,00 1	0.00		our our u program (r			100 L and 0, 1.	0, 1.0, 002	0.00	
10.00 Stand-al one SCHIP charges 0.10.00 0.			IIP) (see instructi	ons for e	ach line)				
11.00 Stand-al one SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero) 12.00 Enter state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 15.00 luncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 grants (sum of lines 8, 12 and 16) 17.00 Total initial obligation of patients approved for charity care (at full patients approved for charity care (at full col. 1, 20, 20, 0 3, 00 charges excluding non-reimbursable cost centers) for the entire facility 17.00 Cost of Initial obligation of patients approved for charity care (at full col. 1, 20, 20, 0 3, 00 charges excluding non-reimbursable cost centers) for the entire facility 17.00 Cost of Initial obligation of patients approved for charity care (at full col. 1, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20	9.00	Net revenue from stand-alone SCHIP					0	9.00	
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9: if < zero then 0 12.00	10.00	Stand-alone SCHIP charges					0	10.00	
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 6, 445, 052 19.00 Eagle excluding non-reimbursable cost centers) for the entire facility cost of initial obligation of patients approved for charity care (at full 6, 306, 919 2, 528, 233 8, 835, 152 20.00 Cost of initial obligation of patients approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 times line 20) 20.00 Partial payment by patients approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 times line 20) 21.00 Cost of initial colligation of patients approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 times line 20) 22.00 Partial payment by patients approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 11 100	11.00	Stand-alone SCHIP cost (line 1 times line 10)					0	11.00	
Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13.00 14.00 15.00	12.00	Difference between net revenue and costs for s	stand-alone SCHIP (line 11 m	inus line 9;	if < zero then	0	12.00	
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 Difference between net revenue and costs for state or local indigent care programs (sum of lines 0 18.00 Difference Differe									
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 6, 445, 052 19.00 19.00 19.00 10.00 19.00 10.00 19.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 10.00 19.00 10.00 19.00 10.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 19.00 10.00 19.00 19.00 10.00 19.00 19.00 10.00 19.									
10) State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 Rivers (line 15 minus line 20) 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 6, 445, 052 19.00 Rivers and local initial obligation of patients approved for charity care (at full 6, 306, 919 2, 528, 233 8, 835, 152 20.00 Cost of initial obligation of patients approved for charity care (at full 6, 306, 919 2, 528, 233 8, 835, 152 20.00 Rivers and line 20) Rivers approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Cost of initial obligation of patients approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Rivers and line 20) Rivers approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Rivers and line 20) Rivers approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Rivers and line 20) Rivers approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Rivers and line 20) Rivers approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Rivers and line 20) Rivers approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Rivers and line 20) Rivers approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 Rivers and line 20) Rivers and line 20 Rivers and line 21 Rivers an									
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrel mbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 6, 445, 052 19.00 20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 11.00 2.00 23.00 Cost of charity care (line 21 minus line 22) 22.00 Partial payment by patients approved for charity care (line 1 1, 850, 339 672, 451 2, 522, 790 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid complex (see instructions) 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 38.00 Cost of uncompensated care (line 23 column 3 plus line 29) 39.00 Cost of uncompensated care (line 23 column 3 plus line 29)	14. 00	9 ,	ocal indigent care	program (Not included	in lines 6 or	0	14. 00	
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line line list if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care or local unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines of ,445,052 line line) 18.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines of ,445,052 line line line line line line line line	15 00		. 1 +imaa lima 14)				0	15 00	
13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care (0) 17.00 (18.00 Government grants, appropriations or transfers for support of hospital operations (19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines									
Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 6, 445, 052 19.00 8, 12 and 16) 19.00 Total initial obligation of patients approved for charity care (at full 6, 306, 919 2, 528, 233 8, 835, 152 20.00 charges excluding non-reimbursable cost centers) for the entire facility (simes line 20) 20.00 Partial payment by patients approved for charity care (line 1 1, 864, 502 747, 416 2, 611, 918 21.00 times line 20) 22.00 Partial payment by patients approved for charity care (line 1 1, 850, 339 672, 451 2, 522, 790 23.00 cost of charity care (line 21 minus line 22) 1, 850, 339 672, 451 2, 522, 790 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients	16.00		state of rocal fillul	gent care	program (iii	ie is illinus iine	U	10.00	
17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) 10			Line)						
18.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines Uninsured patients Insured patients Hool Local Local	17. 00			idi ng char	ity care		0	17. 00	
Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients patients + col. 2)							0	18. 00	
Uninsured patients Total (col. 1 + col. 2) 20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 1,864,502 747,416 2,611,918 21.00 22.00 Partial payment by patients approved for charity care (line 1 times line 20) 1,850,339 672,451 2,522,790 23.00 23.00 Cost of charity care (line 21 minus line 22) 1,850,339 672,451 2,522,790 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 25.00 27.00 Medicare bad debt expense for the entire hospital complex (see instructions) 14,818,371 26.00 736,449 27.00 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 2 minus line 28) 4,163,010 29.00 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,685,800 30.00 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,685,800 30.00 20		1 1 1				ms (sum of lines	6, 445, 052	19. 00	
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charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 1,864,502 747,416 2,611,918 21.00 times line 20) 22.00 Partial payment by patients approved for charity care 14,163 74,965 89,128 22.00 23.00 Cost of charity care (line 21 minus line 22) 1,850,339 672,451 2,522,790 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 14,818,371 26.00 Medicare bad debts for the entire hospital complex (see instructions) 14,818,371 26.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 14,081,922 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,163,010 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,685,800 30.00									
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29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 4,163,010 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,685,800 30.00		,		,			· ·		
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,685,800 30.00			, ,		,				
				ense (line	1 times line	e 28)			
31.00 Total unreambursed and uncompensated care cost (line 19 plus line 30) 13,130,852 31.00		,	,	0.0)					
	31.00	liotal unrelmbursed and uncompensated care cost	(iine 19 plus lin	ie 30)			13, 130, 852	31.00	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARION GENERAL F FXPENSES		CCN: 150011 F	In Lie Period:	u of Form CMS- Worksheet A	2552-10
NECLAS	STITEATION AND ADJUSTMENTS OF THE DALANCE O	I EXI ENSES	TTOVIGET	1	From 07/01/2015 From 06/30/2016		nared:
						11/23/2016 9:	25 am
	Cost Center Description	Sal ari es	Other	lotal (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				,		(col. 3 +-	
		1.00	2.00	3. 00	4. 00	<u>col . 4)</u> 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	050 251	12, 625, 875			11, 490, 283	
4. 00 5. 00	OO400	958, 351 8, 406, 215	19, 178, 798 22, 914, 910			20, 239, 563 31, 171, 670	1
6.00	00600 MAINTENANCE & REPAIRS	0	0		o	0	6. 00
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A	0	0	(1, 445, 534	1, 445, 534	6. 01 6. 02
7. 00	00700 OPERATION OF PLANT	610, 857	4, 284, 783	4, 895, 640	398, 636	5, 294, 276	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	(463, 041	463, 041	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	3, 058, 829 2, 022, 253	3, 058, 829 2, 022, 253		2, 532, 873 523, 890	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 445, 173	96, 939			1, 005, 624	
14. 00	01400 CENTRAL SERVICES & SUPPLY	132, 746	369, 970	'		527, 100	1
15. 00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 371, 296	7, 321, 596	9, 692, 892	2 -4, 051, 111	5, 641, 781	15. 00
30.00	03000 ADULTS & PEDI ATRI CS	7, 279, 242	959, 155	8, 238, 39	7 -1, 140, 314	7, 098, 083	30.00
31.00	03100 NTENSI VE CARE UNI T	2, 343, 087	315, 361	2, 658, 448	17, 987	2, 676, 435	1
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	976, 013	780, 481	1, 756, 494	1 0	1, 756, 494	40.00
42. 00	04200 SUBPROVI DER	0	0	(o	0	42. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		1, 380, 749	1, 380, 749	43. 00
50.00	05000 OPERATING ROOM	0	12, 543, 511	12, 543, 51	1 178, 810	12, 722, 321	50.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	2, 939, 768	2, 745, 336 0	5, 685, 10 ₄		4, 843, 199 843, 365	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o o	0		453, 980	453, 980	1
59.00	05900 CARDI AC CATHETERI ZATI ON	489, 888	1, 648, 199			2, 173, 839	1
60. 00 60. 01	O6000 LABORATORY O6001 ONCOLOGY	2, 357, 050 973, 075	4, 525, 023 593, 199	6, 882, 073 1, 566, 274		6, 863, 691 1, 566, 274	1
60. 02	06002 RADIATION ONCOLOGY	0	0	(o o	0	60. 02
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 170, 072 1, 783, 475	668, 943 265, 084	1, 839, 01! 2, 048, 559		1, 910, 555 2, 048, 559	
69. 00	06900 ELECTROCARDI OLOGY	689, 137	149, 071	838, 208		912, 225	1
69. 01	06901 CARDI AC REHAB	101, 058	4, 298	105, 35	37, 159	142, 515	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	71. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(4, 051, 111	4, 051, 111	1
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	256, 515	111, 515	368, 030	57, 468	425, 498	90.00
91.00	09100 EMERGENCY	3, 962, 583	945, 516			4, 853, 691	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	,		0	92.00
92.01	O9201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	ı o	0		0	0	92. 01
95. 00	09500 AMBULANCE SERVI CES	996, 808	124, 001	1, 120, 80	54, 408	1, 175, 217	95. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		0		ol ol	0	113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	40, 242, 409	98, 252, 646				1
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	16, 930	16, 930	26, 176	42 106	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	10, 430		0 20, 170		192. 00
	19202 VISITOR MEALS	0	0	()	0		192. 02
	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE	95, 383	4, 049 0	99, 432	11, 200	110, 632 0	192. 03
192.05	19205 OWNED PROPERTIES	0	975, 718			88, 836	192. 05
	19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT	27, 367	14, 749 25, 916				192. 08 192. 09
	19214 BREAST PUMPS	0	25, 410	25, 416			192. 10
	19209 LUNG CENTER	101, 833	450, 848			582, 241	1
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	925, 921 462, 897	525, 316 1, 956, 034			1, 496, 219 2, 496, 094	
192. 16	19216 MGH MGH MED ONC	414	1, 307, 315			1, 307, 729	
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	781, 855	2, 267, 678			3, 415, 695	1
	19218 MGH FALRM MED ASSOC 19219 MGH FMC MARION	5, 416 226, 594	90, 420 504, 867	95, 836 731, 46°		760, 365	192. 18 192. 19
193.00	19300 NONPALD WORKERS	0	0		o	0	193. 00
	19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY	281, 595 153, 696	688, 536 401, 882	970, 13 ⁻ 555, 578		971, 370 614, 830	
193. 03	19303 MGH HOSPITALISTS	74, 369	2, 968, 036			3, 042, 405	
	19304 MGH MAR FAM PRACT	752, 406	2, 055, 639			2, 808, 045	1
	19305 MGH FMC SWAYZEE 19306 MGH PEDIATRIC CTR	73, 226 271, 864	146, 763 1, 029, 231			245, 675 1, 364, 651	1
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		, , 1 2 3 1	., ., , . , . , . , . , . , . , .	1 30, 630	., 23., 331	

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
				From 07/01/2015 To 06/30/2016	Date/Time Pre	narod:
				10 00/30/2010	11/23/2016 9:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
193.07 19307 MGH SPECIALTY PHYS	77, 700	271, 582			· ·	
193.08 19308 MGH FMC CONVERSE	108, 440	185, 806			294, 553	
193.09 19309 MGH UPLAND HEALTH	365, 258	1, 064, 986	1, 430, 24	4 6, 639		
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	432, 622	1, 787, 633	2, 220, 25	5 0	2, 220, 255	
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	0	0		314, 811		
194. 04 07953 MGH WORK SOLUTIONS	362, 216	478, 929				1
194.05 07954 MGH TAYLOR UNIVERSITY	51, 679	99, 301			150, 980	
194.08 07957 MGH SMMP BLDG	0	289, 770			289, 770	1
194.09 07958 MGH AMBUCARE BLDG	0	53, 441			53, 441	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	4, 708				194. 10
194. 11 07960 FAI RMOUNT	0	14, 913	14, 91	3 0	14, 913	l .
194. 12 07961 GAS_CLTY	0	57, 067			57, 067	l
194. 13 07962 LYONS	0	16, 051			16, 051	1
194. 14 07964 WABASH	0	495	49	5 0		194. 14
200.00 TOTAL (SUM OF LINES 118-199)	45, 875, 160	118, 007, 255	163, 882, 41	5 0	163, 882, 415	200. 00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (F EXPENSES	Provi der	CCN: 150011	Peri od:	Worksheet A
					From 07/01/2015 To 06/30/2016	Date/Time Prepared:
					1.0 00, 00, 20.0	11/23/2016 9: 25 am
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8) 6.00	For Allocation 7.00	1		
	GENERAL SERVICE COST CENTERS	0.00	7.00			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-96, 482	11, 393, 801			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-627, 457	19, 612, 106			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-10, 825, 419	20, 346, 251			5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	_			6. 00
6. 01	00601 CAFETERI A	-26, 059				6. 01
6. 02	00602 CAFETERI A	0	_	2		6. 02
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-121, 696				7. 00 8. 00
9. 00	00900 HOUSEKEEPING	-4, 126 -2, 479		1		9.00
10. 00	01000 DI ETARY	-7, 915				10.00
13. 00	01300 NURSING ADMINISTRATION	0		1		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	-932		1		14. 00
15. 00	01500 PHARMACY	-34, 463		1		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_				
30. 00	03000 ADULTS & PEDI ATRI CS	-35, 777		1		30.00
31.00	03100 I NTENSI VE CARE UNI T	-424		1		31.00
40.00	04000 SUBPROVI DER - I PF	74.2(2	_	•		40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	-74, 262	1, 682, 232			41.00
43. 00	04300 NURSERY		1, 380, 749			43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS		1,300,747	1		43.00
50. 00	05000 OPERATING ROOM	-13, 471	12, 708, 850			50.00
51.00	05100 RECOVERY ROOM	0		1		51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-162, 800	4, 680, 399			54.00
57. 00	05700 CT SCAN	0				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	453, 980	1		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-7, 215		1		59.00
60.00	06000 LABORATORY	-87, 687		1		60.00
60. 01 60. 02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	-9, 298 0		1		60. 01
65. 00	06500 RESPIRATORY THERAPY	-4, 780		1		65. 00
66. 00	06600 PHYSI CAL THERAPY	-4, 780				66. 00
69. 00	06900 ELECTROCARDI OLOGY	-53, 950				69. 00
69. 01	06901 CARDI AC REHAB	-5				69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	O			72. 00
73.00		-400	4, 050, 711			73. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	-196		1		90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-165, 985	4, 687, 706	9		91. 00 92. 00
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0	o			92. 01
72.01	OTHER REIMBURSABLE COST CENTERS			<u>′1</u>		72.01
95.00	09500 AMBULANCE SERVICES	-57, 351	1, 117, 866			95. 00
	SPECIAL PURPOSE COST CENTERS			•		
113. 0	11300 I NTEREST EXPENSE	0	_	1		113. 00
118. 0		-12, 420, 722	125, 812, 714	ļ		118. 00
100.0	NONREI MBURSABLE COST CENTERS		10.40			100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	0		1		190. 00 192. 00
	2 19202 VISITOR MEALS					192.00
	3 19203 GREAT BEGINNINGS/MATERNAL	0	_	S S		192. 03
	4 19204 LI FELI NE	Ö				192. 04
192. 0	19205 OWNED PROPERTIES	0	88, 836			192. 05
192.0	B 19211 PARISH NURSING	0	57, 575	5		192. 08
	9 19212 BIOTERRORISM GRANT	0	56, 482	2		192. 09
	19214 BREAST PUMPS	0	_	1		192. 10
	2 19209 LUNG CENTER	-30, 768				192. 12
	1 19210 MGH PHYS PRACT MGMT	-64, 421				192. 14
	5 19215 MGH MARION SURGEONS 5 19216 MGH MGH MED ONC	-107, 646		1		192. 15 192. 16
	7 19217 MGH MGH MED ONC	-320, 299		1		192. 17
	B 19218 MGH FAIRM MED ASSOC	-15, 099		1		192. 17
	9 19219 MGH FMC MARION	-45, 686		1		192. 19
	19300 NONPALD WORKERS	0		1		193. 00
	1 19301 MGH FMC NORTHWOOD	0	971, 370)		193. 01
	2 19302 MGH FMC GAS CITY	-80, 641	534, 189	1		193. 02
	3 19303 MGH HOSPI TALI STS	0	-, ,			193. 03
	4 19304 MGH MAR FAM PRACT	0	2, 808, 045	1		193. 04
	5 19305 MGH FMC SWAYZEE	-28, 965	l .	1		193. 05
	5 19306 MGH PEDIATRIC CTR 7 19307 MGH SPECIALTY PHYS	-89, 847 -42, 576		1		193. 06 193. 07
		-44.0/0		1		[173.07
	19308 MGH FMC CONVERSE	0		3		193. 08

 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

Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7. 00	
193.09 19309 MGH UPLAND HEALTH	0	1, 436, 883	193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0	193. 11
193. 12 19312 OB/GYN	0	2, 220, 255	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	193. 15
194.00 07963 OTHER NONREI MBURSABLE	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	314, 811	194. 03
194.04 07953 MGH WORK SOLUTIONS	-103, 875	744, 403	194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	150, 980	194. 05
194.08 07957 MGH SMMP BLDG	0	289, 770	194. 08
194.09 07958 MGH AMBUCARE BLDG	0	53, 441	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	4, 708	194. 10
194. 11 07960 FAI RMOUNT	0	14, 913	194. 11
194. 12 07961 GAS CLTY	0	57, 067	194. 12
194. 13 07962 LYONS	0	16, 051	194. 13
194. 14 07964 WABASH	0	495	194. 14
200.00 TOTAL (SUM OF LINES 118-199)	-13, 350, 545	150, 531, 870	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 07/01/2015 | To 06/30/2016 | Date/Time Prepared:

		То	06/30/2016 Date/Time P 11/23/2016	
	Cost Center Description	CMS Code	Standard Label For	71 20 4
			Non-Standard Codes	
		1.00	2. 00	
	GENERAL SERVICE COST CENTERS			
1. 00 4. 00	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	00100 00400		1. 00 4. 00
5.00	ADMINISTRATIVE & GENERAL	00500		5. 00
6.00	MAINTENANCE & REPAIRS	00600		6. 00
6. 01	CAFETERI A	00601		6. 01
6. 02 7. 00	CAFETERIA	00602 00700		6. 02
8. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	00800		7. 00 8. 00
9. 00	HOUSEKEEPI NG	00900		9. 00
10. 00	DI ETARY	01000		10. 00
13.00	NURSI NG ADMI NI STRATI ON	01300		13.00
14. 00 15. 00	CENTRAL SERVICES & SUPPLY PHARMACY	01400 01500		14. 00 15. 00
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	01300		13.00
30.00	ADULTS & PEDI ATRI CS	03000		30.00
31. 00	INTENSIVE CARE UNIT	03100		31. 00
40. 00 41. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	04000 04100		40. 00 41. 00
42.00	SUBPROVI DER	04200		42.00
43. 00	NURSERY	04300		43. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATI NG ROOM	05000		50.00
51. 00 54. 00	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	05100 05400		51. 00 54. 00
57. 00	CT SCAN	05700		57. 00
58. 00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58. 00
59. 00	CARDI AC CATHETERI ZATI ON	05900		59. 00
60. 00 60. 01	LABORATORY ONCOLOGY	06000 06001		60. 00
60. 01	RADI ATI ON ONCOLOGY	06001		60.01
65. 00	RESPI RATORY THERAPY	06500		65. 00
66. 00	PHYSI CAL THERAPY	06600		66. 00
69. 00	ELECTROCARDI OLOGY	06900		69. 00
69. 01 71. 00	CARDI AC REHAB MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	06901 07100		69. 01 71. 00
71.00	IMPL. DEV. CHARGED TO PATIENTS	07100		71.00
73. 00	DRUGS CHARGED TO PATIENTS	07300		73. 00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91. 00 92. 00	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	09100 09200		91.00
92. 01	OBSERVATION BEDS (DISTINCT PART)	09201		92. 01
	OTHER REIMBURSABLE COST CENTERS			
95. 00	AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	09500		95. 00
113 00	INTEREST EXPENSE	11300		113. 00
	SUBTOTALS (SUM OF LINES 1-117)	1.000		118. 00
	NONREI MBURSABLE COST CENTERS			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
	PHYSICIANS' PRIVATE OFFICES VISITOR MEALS	19200 19202		192. 00 192. 02
	GREAT BEGINNINGS/MATERNAL	19203		192. 02
192.04	LI FELI NE	19204		192. 04
	OWNED PROPERTIES	19205		192. 05
	PARI SH NURSI NG BI OTERRORI SM GRANT	19211 19212		192. 08 192. 09
	BREAST PUMPS	19214		192. 10
	LUNG CENTER	19209		192. 12
	MGH PHYS PRACT MGMT	19210		192. 14
	MGH MARI ON SURGEONS	19215		192. 15 192. 16
	MGH MGH MED ONC MGH FMC SOUTH	19216 19217		192. 16
	MGH FAIRM MED ASSOC	19218		192. 18
192. 19	MGH FMC MARION	19219		192. 19
	NONPALD WORKERS	19300		193. 00
	MGH FMC NORTHWOOD MGH FMC GAS CITY	19301 19302		193. 01 193. 02
	MGH HOSPITALISTS	19302		193. 02
	MGH MAR FAM PRACT	19304		193. 04
	MGH FMC SWAYZEE	19305		193. 05
193. 06	MGH PEDIATRIC CTR	19306		193. 06

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COST CENTERS USED IN COST REPORT	Provi der CCN: 150011	Peri od: Worksheet Non-CMS W
		From 07/01/2015

		o 06/30/2016 Date/Time Prepared 11/23/2016 9:25 au
Cost Center Description	CMS Code	Standard Label For Non-Standard Codes
	1.00	2.00
193. 07 MGH SPECIALTY PHYS	19307	193.
193.08 MGH FMC CONVERSE	19308	193.
193.09 MGH UPLAND HEALTH	19309	193.
193. 10 MGH MGH WOMENS CTR	19310	193.
193. 11 MGH MGH PSYCHIATRY	19311	193.
193. 12 OB/GYN	19312	193.
193.15 MGH RIVER VIEW BLDG	19315	193.
194.00 OTHER NONREIMBURSABLE	07963	194.
194. 01 MOW	07950	194.
194. 02 MENTAL HEALTH	07951	194.
194. 03 ADVERTI SI NG	07952	194.
194.04 MGH WORK SOLUTIONS	07953	194.
194. 05 MGH TAYLOR UNI VERSI TY	07954	194.
194.08 MGH SMMP BLDG	07957	194.
194.09 MGH AMBUCARE BLDG	07958	194.
194.10 MGH 106 LYONS BLDG	07959	194.
194. 11 FAI RMOUNT	07960	194.
194. 12 GAS CITY	07961	194.
194. 13 LYONS	07962	194.
194. 14 WABASH	07964	194.
200.00 TOTAL (SUM OF LINES 118-199)		200.

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

					To 06/30/2016 Date/Time Prepared: 11/23/2016 9:25 am
		Increases			1172372310 7.20 diii
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - SATELLITE OFFICE RECLASS	3.00	4.00	5.00	
1.00	ELECTROCARDI OLOGY	69.00	9, 167	1, 897	1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	7 <u>1, 7</u> 33	1 <u>3, 0</u> 22	2. 00
	O B - CAFETERIA RECLASS		80, 900	14, 919	
1. 00	ADMINISTRATIVE & GENERAL	5. 00	O	81, 863	1. 00
2.00	CAFETERI A	6. 01	ō	1, 445, 534	2. 00
	0		0	1, 527, 397	
1 00	C - ADMIN DIRECTOR RECLASS	4 00	64, 684	0	1.00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT CENTRAL SERVICES & SUPPLY	4. 00 14. 00	24, 384	0	1. 00 2. 00
3. 00	ADULTS & PEDIATRICS	30.00	240, 435	0	3.00
4.00	INTENSIVE CARE UNIT	31. 00	17, 987	0	4.00
5.00	CARDIAC CATHETERIZATION	59. 00	35, 752	0	5. 00
6.00	RESPIRATORY THERAPY	65.00	71, 540	0	6.00
7. 00 8. 00	ELECTROCARDI OLOGY CARDI AC REHAB	69. 00 69. 01	46, 060 21, 902	0	7. 00 8. 00
9. 00	CLINIC	90.00	24, 129	Ö	9.00
11. 00	AMBULANCE SERVICES	95.00	54, 408	0	11.00
12.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	26, 176	0	12. 00
13. 00	CANTEEN GREAT BEGINNINGS/MATERNAL	192. 03	11, 200	0	13.00
14. 00	PARI SH NURSI NG	192. 03	11, 433	0	14.00
15. 00	BI OTERRORI SM GRANT	192. 09	30, 566	0	15. 00
	0		680, 656		
4 00	D - ADVERTISING	104.00	202 244	04.747	1.00
1. 00	ADVERTISING	1 <u>94.</u> 03	223, 044 223, 044	9 <u>1, 7</u> 67 91, 767	1.00
	E - LEASED PROPERTY		223, 044	71, 707	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	37, 730	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	121, 095	2.00
3.00	OPERATION OF PLANT	7. 00	0	427, 569	3.00
4. 00 5. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	8, 763 28, 429	4. 00 5. 00
6. 00	OPERATING ROOM	50.00	o	178, 810	6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	O	306, 332	7. 00
8. 00	CT SCAN	57. 00	0	20, 884	8. 00
9. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	23, 533	9.00
10. 00	LABORATORY	60.00	0	74, 623	10.00
11. 00	ELECTROCARDI OLOGY	69.00	ō	16, 893	11. 00
12.00	CARDI AC REHAB	69. 01	0	15, 257	12. 00
13.00	CLINIC CENTER	90.00	0	33, 339	13.00
14. 00 15. 00	LUNG CENTER PARI SH NURSI NG	192. 12 192. 08	0	29, 560 4, 026	14. 00 15. 00
16. 00	MGH PHYS PRACT MGMT	192. 14	ő	44, 982	16. 00
17. 00	MGH MARION SURGEONS	192. 15	О	77, 163	17. 00
18. 00	MGH FMC SOUTH	192. 17	0	341, 064	18. 00
19. 00	MGH FAIRM MED ASSOC MGH FMC MARION	192. 18	0	307	19. 00
20. 00 21. 00	MGH FMC MARION MGH WORK SOLUTIONS	192. 19 194. 04	0	28, 904 7, 133	20. 00 21. 00
22. 00	MGH FMC NORTHWOOD	193. 01	ő	1, 239	22.00
23. 00	MGH FMC GAS CITY	193. 02	o	59, 252	23. 00
24. 00	MGH FMC SWAYZEE	193. 05	0	25, 686	24.00
25. 00	MGH PEDIATRIC CTR	193. 06	0	63, 556	25. 00
26. 00 27. 00	MGH SPECIALTY PHYS MGH FMC CONVERSE	193. 07 193. 08	0	39, 399 307	26. 00 27. 00
28. 00	MGH UPLAND HEALTH	193. 09	o	6, 639	28.00
	0			2, 022, 474	
	F - PHARMACY RECLASS	70.00	ما ا		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	4,05 <u>1,1</u> 11 4,051,111	1.00
	G - CT/MRI RECLASS		J	4,001,111	
1.00	CT SCAN	57. 00	424, 497	396, 421	1.00
2.00	MAGNETIC RESONANCE I MAGING	58. 00	221, 675	207, 013	2.00
	(MRI)	+	6/4 172	603, 434	
	H - SHORT TERM DISABILITY REC	LASS	646, 172	003, 434	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 706	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	o	36, 220	2.00
4.00	PHARMACY	15.00	0	2, 452	4.00
5. 00 6. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	24, 783 14, 350	5. 00 6. 00
7. 00	SUBPROVI DER - I RF	41.00	o	5, 303	7.00
	1	29		., ===	

Peri od: Worksheet A-6 From 07/01/2015 To 06/30/2016 Date/Time Prepared: 11/23/2016 9:25 am

						11/23/2016 9:	25 am
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4. 00	5. 00			
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 442	2		9. 00
11.00	LABORATORY	60.00	0	15, 553	3		11.00
12.00	ONCOLOGY	60. 01	0	19, 640			12.00
13.00	RESPI RATORY THERAPY	65.00	0	9, 721			13.00
14.00	PHYSI CAL THERAPY	66.00	0	4, 751			14.00
17.00	EMERGENCY	91.00	0	11, 974			17.00
18.00	AMBULANCE SERVICES	95.00	o	2, 097	,		18.00
19.00	MGH PHYS PRACT MGMT	192. 14	o	106			19.00
20.00	MGH MARION SURGEONS	192. 15	o	602			20.00
21.00	MGH FMC SOUTH	192. 17	0	2, 135	5		21.00
22.00	MGH FMC MARION	192. 19	0	1, 078	3		22. 00
23.00	MGH FMC GAS CITY	193. 02	0	951			23. 00
24.00	MGH MAR FAM PRACT	193. 04	0	3, 660			24.00
25.00	LUNG CENTER	192. 12	0	607	,		25. 00
26.00	MGH PEDIATRIC CTR	193. 06	o	2, 246			26.00
27.00	MGH SPECIALTY PHYS	193. 07	0	284			27. 00
28. 00	MGH FMC NORTHWOOD	193. 01	o	2, 815	5		28. 00
30.00	OB/GYN	193. 12	0	135			30.00
			— — — _ō	170, 611			1
	I - NURSERY RECLASS	<u>'</u>					1
1.00	NURSERY	43.00	945, 953	434, 796			1.00
		$ +$	945, 953	434, 796			
	J - SMMP HOUSEKEEPING RECLASS	5			•		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 821			1.00
2.00	OPERATION OF PLANT	7. 00	0	1, 633	3		2.00
3.00	HOUSEKEEPI NG	9. 00	0	360			3.00
4.00	DI ETARY	10.00	0	605	5		4.00
5.00	MGH FMC SOUTH	192. 17	o	25, 098	3		5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	22, 385			6.00
7.00	CT SCAN	57.00	0	1, 563			7. 00
8.00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 759			8.00
	(MRI)		Ī	.,			
9.00	LABORATORY	60.00	0	2, 814			9.00
	TOTALS — — — — —		— — — _ō	72, 038			
	K - LAUNDRY RECLASS	·		,	•		1
1.00	LAUNDRY & LINEN SERVICE	8.00	0	463, 041			1.00
	TOTALS	<u> </u>	— — —	463, 041			1
500.00	Grand Total: Increases		2, 576, 725		-		500.00
	•			, , , , , , , , , , , , , , , , , , , ,	1		'

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150011

| Period: | From 07/01/2015 | To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: | 11/23/2016 9: 25 am

Cost Center Line # Salarry Other Nest A-7 Ref							11/23/2016 9: 2	<u>5 am</u>
A			Decreases	6.1	011	w		
A. SATELLITE OFFICE FOR ASS 10.00 9,167 1,897 0 1, 1,809 10 1, 1,809 1, 1,909 1, 1,809 1, 1,909 1								
1.00			7.00	0.00	7. 00	10.00		
BOOK 14, 919 100 14, 919 100 11, 919 100 11, 415 534 10 12, 20 11, 20 11, 20 11, 20	1.00		60.00	9, 167	1, 897	0		1. 00
CAN FIRTH REGIONS	2.00	LABORATORY	60.00	7 <u>1, 7</u> 33	13, 022	0		2.00
DITINATY 10.00		0		80, 900	14, 919			
DITFARY 10.00						_1		
Color		1	1	- 1				1.00
0 - ADM N DIRECTOR RECLASS 1.00 1.10 ADM NUMBER TO N OF LANT 7.00 30.506 0 0 0 2.20 0 0 0 2.00 0 0 0 0 0 0 0 0 0	2.00	DIETARY	10.00			— — — 4		2. 00
1.00		C - ADMIN DIRECTOR RECLASS		o _l	1, 321, 371			
2,00	1.00		5. 00	53, 423	0	0		1. 00
A.00	2.00		7.00		0	o		2.00
5.00 MFRERNCY 91.00 54,408 0 0 6 6 6 6 6 6 6 6						- 1		3. 00
6.00			I					4. 00
7.00		EMERGENCY	I		-	- 1		5. 00
B				~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	-			6. 00 7. 00
9.00 11.00 12.00 0.00 0.00 0.00 0.00 0.00			I	0				8. 00
11.00			I	ő	-			9. 00
13.00				0	0	o		11.00
15.00	12.00		0.00	0	0	0		12.00
15.00			I	0	-			13.00
O				0	0	-		14.00
D - ADVERTIS ING	15. 00			0	0	9		15. 00
1.00		D _ ADVERTISING		080, 656	O O			
0	1, 00		5 00	223 044	91 767	n		1. 00
1.00 NEW CAP REL COSTS-BLDG & 1.00 0 1.135, 592 10		0						
FIXT OWNED PROPERTIES 192.05 0 886,882 0 3.3 3.00 0.00 0.00 0 0 0 0 0 3.3 4.00 5.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0								
2.00	1.00		1. 00	0	1, 135, 592	10		1. 00
3.00 0.00 0.00 0 0 0 3 4 4 5 5 6 6 6 6 6 6 6 6	2 00		102.05		004 000			2 00
4.00		OWNED PROPERTIES		-				2. 00 3. 00
5.00			I					4. 00
7. 00			l .	-				5. 00
8.00 0.00 0.00 0 0 0 0 0	6.00		0.00	0	0	O		6.00
9.00 9.00 10.00				0				7. 00
10.00			•	0				8. 00
11.00			I .	0	-			9.00
12.00			•	0			• • • • • • • • • • • • • • • • • • •	10.00
13.00				0	-	- 1	1	11. 00 12. 00
14. 00			•				•	13. 00
16. 00			•	Ö		- 1		14. 00
17. 00	15.00		0.00	O	0	o		15.00
18.00	16.00		•	0				16. 00
19,00			I		-		1	17. 00
20. 00				-1				18.00
21. 00 22. 00 23. 00 0. 00 0. 00 0. 00 0. 00 24. 00 25. 00 26. 00 27. 00 0. 00				-1		- 1		19. 00 20. 00
22. 00				- 1				21. 00
23. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 20				- 1				22. 00
25. 00 26. 00 26. 00 27. 00 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				Ö	-			23. 00
26. 00	24.00		0.00	O	0	o		24.00
27. 00 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				o	0			25. 00
28. 00				0	0			26. 00
1.00 PHARMACY 15.00 0 4,051,111 0 0 1.00 0 4,051,111 0 0 0 4,051,111 0 0 0 4,051,111 0 0 0 4,051,111 0 0 0 4,051,111 0 0 0 4,051,111 0 0 0 4,051,111 0 0 0 0 0 0 0 0 0				0	0	- 1		27. 00
The first of the	28. 00			의	0	9		28. 00
1. 00 PHARMACY		F - PHARMACY RECLASS		U	2,022,474			
1.00	1.00		15. 00	O	4, 051, 111	0		1. 00
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 646, 172 603, 434 0 0 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	4, 051, 111			
2. 00	1 00		E4 00	/ / / 470	(00.40.1	51		1 00
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 4,706 0 0 0 1.		KADI ULUGY-DI AGNUSTI C		646, 172	603, 434			1.00
H - SHORT TERM DISABILITY RECLASS	∠. ∪∪			$-\frac{0}{646}$	603 434	— — — Ч		2. 00
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 4, 706 0 0 2. 00 ADMI NI STRATI VE & GENERAL 5. 00 36, 220 0 0 4. 00 PHARMACY 15. 00 2, 452 0 0 5. 00 ADULTS & PEDI ATRI CS 30. 00 24, 783 0 0 6. 00 I NTENSI VE CARE UNI T 31. 00 14, 350 0 0 7. 00 SUBPROVI DER - I RF 41. 00 5, 303 0 0 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 4, 442 0 0		H - SHORT TERM DISABILITY REC	LASS	040, 172	003, 434			
2. 00 ADMI NI STRATI VE & GENERAL 5. 00 36, 220 0 0 0 4. 00 PHARMACY 15. 00 2, 452 0 0 0 4. 00 4. 00 PHARMACY 15. 00 2, 452 0 0 0 0 5. 00 0 0 5. 00 0 0 0 0 0 0 0 0	1.00			4, 706	0	0		1. 00
5. 00 ADULTS & PEDIATRICS 30. 00 24, 783 0 0 0 5. 6. 00 INTENSIVE CARE UNIT 31. 00 14, 350 0 0 0 6. 7. 00 SUBPROVI DER - I RF 41. 00 5, 303 0 0 0 7. 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 4, 442 0 0 0 9.	2.00		5. 00	36, 220				2.00
6. 00 INTENSIVE CARE UNIT 31. 00 14, 350 0 0 0 6. 7. 00 SUBPROVI DER - I RF 41. 00 5, 303 0 0 7. 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 4, 442 0 9.								4. 00
7. 00 SUBPROVI DER - I RF 41. 00 5, 303 0 0 9. 00 7. 00 RADI OLOGY-DI AGNOSTI C 54. 00 4, 442 0 9.						- 1		5. 00
9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 4, 442 0 0 0 9.		l l			-	- 1		6. 00
								7.00
11.00 [2.00] 10,000 0] 0] 0]								9. 00 11. 00
	11.00		30.00	10, 000	O ₁	<u> </u>	I	11.00

						11/23/2016 9: 25 ar
		Decreases				
	Cost Center	Li ne #	Sal ary	Other V	Vkst. A-7 Ref.	
	6. 00	7.00	8.00	9. 00	10. 00	
12.00	ONCOLOGY	60. 01	19, 640	0	0	12.
13.00	RESPI RATORY THERAPY	65.00	9, 721	0	0	13.
14.00	PHYSI CAL THERAPY	66.00	4, 751	0	0	14.
17. 00	EMERGENCY	91.00	11, 974	0	O	17.
18.00	AMBULANCE SERVICES	95.00	2, 097	0	0	18.
19.00	MGH PHYS PRACT MGMT	192. 14	106	0	0	19.
20.00	MGH MARION SURGEONS	192. 15	602	0	O	20.
21.00	MGH FMC SOUTH	192. 17	2, 135	0	o	21.
22.00	MGH FMC MARION	192. 19	1, 078	0	o	22.
23.00	MGH FMC GAS CITY	193. 02	951	0	O	23.
24.00	MGH MAR FAM PRACT	193. 04	3, 660	0	o	24.
25.00	LUNG CENTER	192. 12	607	0	o	25.
26.00	MGH PEDIATRIC CTR	193. 06	2, 246	0	o	26.
27.00	MGH SPECIALTY PHYS	193. 07	284	0	o	27.
28.00	MGH FMC NORTHWOOD	193. 01	2, 815	0	o	28.
30.00	OB/GYN	193. 12	135	0	o	30.
	0 — — — — —		170, 611			
	I - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	945, 953	434, 796	0	1.
	0 — — — — —		945, 953	434, 796		
	J - SMMP HOUSEKEEPING RECLASS	5	<u> </u>		'	
1.00	HOUSEKEEPI NG	9.00	0	72, 038	0	1.
2.00		0.00	O	0	o	2.
3.00		0.00	O	0	o	3.
4.00		0.00	O	0	o	4.
5.00		0.00	O	0	o	5.
6.00		0.00	o	0	o	6.
7.00		0.00	o	0	o	7.
8.00		0.00	o	0	o	8.
9.00		0.00	o	0	ol	9.
	TOTALS			72, 038		
	K - LAUNDRY RECLASS	<u>'</u>		· · ·	'	
1.00	HOUSEKEEPI NG	9.00	0	463, 041	0	1.
	TOTALS	<u> </u>		463, 041		
500.00	Grand Total: Decreases		2, 747, 336	9, 280, 977		500.
	1	' '			ı	

Peri od: Worksheet A-6 From 07/01/2015 Non-CMS Worksheet To 06/30/2016 Date/Ti me Prepared: 11/23/2016 9:25 am

							06/30/2016	11/23/2016 9:	
		Increa		0.11		Decre		2.1	
	Cost Center	Li ne #	Sal ary	Other	Cost Center	Li ne #	Sal ary	Other	
	2.00 A - SATELLITE OFFICE R	3. 00	4. 00	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	ELECTROCARDI OLOGY	69. 00	9, 167	1 897	LABORATORY	60.00	9, 167	1, 897	1. 00
2. 00	RADI OLOGY-DI AGNOSTI C	54. 00	71, 733		LABORATORY	60.00	71, 733	13, 022	2. 00
	0		80, 900	14, 919			80, 900	14, 919	
	B - CAFETERIA RECLASS								
1.00	ADMINISTRATIVE &	5. 00	0	81, 863	DI ETARY	10.00	0	81, 863	1. 00
0.00	GENERAL	, 01		4 445 504	DI ETADY	10.00		4 445 504	
2.00	CAFETERI A	6. 01	0	<u>1, 445, 534</u> 1, 527, 397	DIETARY	10.00		<u>1, 445, 534</u> 1, 527, 397	2. 00
	C - ADMIN DIRECTOR REC	224 1	<u> </u>	1, 527, 397	Į0		<u> </u>	1, 527, 397	
1. 00	EMPLOYEE BENEFITS	4. 00	64, 684	C	ADMINISTRATIVE &	5.00	53, 423	0	1. 00
	DEPARTMENT		- 1, 1	_	GENERAL				
2.00	CENTRAL SERVICES &	14. 00	24, 384	C	OPERATION OF PLANT	7.00	30, 566	0	2. 00
	SUPPLY								
3.00	ADULTS & PEDIATRICS	30. 00	240, 435	C	NURSI NG	13. 00	536, 488	0	3. 00
4 00	INTENSIVE CADE UNIT	31. 00	17 007	c	ADMI NI STRATI ON RADI OLOGY-DI AGNOSTI C	E4 00	5, 771	0	4.00
4. 00 5. 00	INTENSIVE CARE UNIT	59.00	17, 987 35, 752		EMERGENCY	54. 00 91. 00	5, 771	0	4. 00 5. 00
5.00	CATHETERI ZATI ON	39.00	33, 732	C	LINERGENCT	91.00	54, 400	U	5.00
6. 00	RESPIRATORY THERAPY	65. 00	71, 540	C		0.00	0	0	6. 00
7. 00	ELECTROCARDI OLOGY	69. 00	46, 060	C		0.00	0	0	7. 00
8.00	CARDI AC REHAB	69. 01	21, 902	C		0.00	0	0	8. 00
9.00	CLINIC	90.00	24, 129	C		0.00	0	0	9. 00
11. 00	AMBULANCE SERVICES	95. 00	54, 408	C		0.00	0	0	11. 00
12.00	GIFT, FLOWER, COFFEE	190. 00	26, 176	C		0.00	0	0	12. 00
10.00	SHOP & CANTEEN	100.00	44 000						40.00
13. 00	GREAT BEGI NNI NGS/MATERNAL	192. 03	11, 200	C		0.00	o	0	13. 00
14. 00	PARI SH NURSI NG	192. 08	11, 433	C		0.00	0	0	14. 00
15. 00	BI OTERRORI SM GRANT	192. 09	30, 566			0.00	0	0	15. 00
10.00	0	172.07	680, 656	— — <u> </u>	0 — — — —	0.00	680, 656	— — <u> </u>	10.00
	D - ADVERTISING				1.				
1.00	ADVERTI SI NG	194. 03	223, 044	91, 767	ADMINISTRATIVE &	5.00	223, 044	91, 767	1.00
					GENERAL				
	0		223, 044	91, 767	[0		223, 044	91, 767	
1. 00	E - LEASED PROPERTY EMPLOYEE BENEFITS	4. 00	o	27 720	NEW CAP REL	1.00	ol	1, 135, 592	1. 00
1.00	DEPARTMENT	4.00	ď	37, 730	COSTS-BLDG & FLXT	1.00		1, 133, 372	1.00
2.00	ADMI NI STRATI VE &	5. 00	o	121, 095	OWNED PROPERTIES	192. 05	0	886, 882	2. 00
	GENERAL			•					
3.00	OPERATION OF PLANT	7. 00	0	427, 569		0.00	0	0	3. 00
4. 00	HOUSEKEEPI NG	9. 00	0	8, 763	•	0.00	0	0	4. 00
5. 00	DI ETARY	10.00	0	28, 429	•	0.00	0	0	5. 00
6.00	OPERATING ROOM	50.00	0	178, 810	i e	0.00	0	0	6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	306, 332		0.00	O O	0	7. 00
8. 00 9. 00	CT SCAN MAGNETIC RESONANCE	57. 00 58. 00	0	20, 884 23, 533	I .	0.00	0	0	8. 00 9. 00
7.00	I MAGING (MRI)	36.00	ď	23, 333		0.00	٥	U	7.00
10.00	LABORATORY	60.00	o	74, 623		0.00	0	0	10. 00
11. 00	ELECTROCARDI OLOGY	69.00	o	16, 893		0.00	0	0	11. 00
12.00	CARDI AC REHAB	69. 01	o	15, 257		0.00	0	0	12.00
13.00	CLINIC	90.00	0	33, 339		0.00	0	0	13.00
14.00	LUNG CENTER	192. 12	0	29, 560		0.00	0	0	14. 00
15. 00	PARISH NURSING	192. 08	0	4, 026		0.00	0	0	15. 00
16.00	MGH PHYS PRACT MGMT	192. 14	0	44, 982	i e	0.00	0	0	16. 00
17. 00	MGH MARI ON SURGEONS	192. 15	0	77, 163		0.00	0	0	17. 00
18.00	MGH FMC SOUTH	192. 17 192. 18	O O	341, 064		0.00	O O	0	18. 00 19. 00
19. 00 20. 00	MGH FAIRM MED ASSOC MGH FMC MARION	192. 18	0	307 28, 904		0.00	0	0	20. 00
21. 00	MGH WORK SOLUTIONS	194. 04	0	7, 133	I .	0.00	0	0	21. 00
22. 00	MGH FMC NORTHWOOD	193. 01	Ö	1, 239	I .	0.00	0	0	22. 00
23. 00	MGH FMC GAS CITY	193. 02	ől	59, 252		0.00	ol	0	23. 00
24. 00	MGH FMC SWAYZEE	193. 05	ol	25, 686		0.00	ol	Ö	24. 00
25. 00	MGH PEDIATRIC CTR	193. 06	o	63, 556		0.00	0	0	25. 00
26. 00	MGH SPECIALTY PHYS	193. 07	o	39, 399		0.00	0	0	26. 00
27. 00	MGH FMC CONVERSE	193. 08	0	307		0.00	0	0	27. 00
28. 00	MGH UPLAND HEALTH	193. 09	0			0.00	•	0	28. 00
	DUADMACK DECLACE		0	2, 022, 474	ĮU		0	2, 022, 474	
1 00	F - PHARMACY RECLASS DRUGS CHARGED TO	73. 00	ما	4, 051, 111	DUADMACV	15.00	ol	4, 051, 111	1 00
1. 00	PATI ENTS	/3.00	0	4, 001, 111	I HARWACI	13.00	٩	4, 031, 111	1. 00
	0	\vdash	₀	4, 051, 111	0 — — —	\vdash	0	4, 051, 111	
	•		-1		'	. '	-1		

					Trovider con. 10		rom 07/01/2015 o 06/30/2016	Non-CMS Works Date/Time Pre 11/23/2016 9:	pared:
		Increa				Decre			
	Cost Center	Li ne #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	0ther	
	2.00	3. 00	4. 00	5. 00	6. 00	7.00	8. 00	9. 00	
	G - CT/MRI RECLASS								
1.00	CT SCAN	57. 00	424, 497		RADI OLOGY-DI AGNOSTI C	54.00	646, 172	603, 434	1. 00
2.00	MAGNETIC RESONANCE	58. 00	221, 675	207, 013		0.00	0	0	2. 00
	IMAGING (MRI)					\perp		— — . .	
	0		646, 172	603, 434	0		646, 172	603, 434	
	H - SHORT TERM DISABIL		ASS	0.1	ENDLOYEE DENEELTO	1 4 00			
1. 00	EMPLOYEE BENEFITS	4. 00	O		EMPLOYEE BENEFITS	4.00	4, 706	0	1. 00
2 00	DEPARTMENT	F 00		I-	DEPARTMENT	F 00	27, 220	0	2 00
2.00	ADMI NI STRATI VE &	5. 00	0		ADMINISTRATIVE &	5.00	36, 220	0	2. 00
4 00	GENERAL PHARMACY	15 00			GENERAL	15 00	2 452	0	4 00
4.00		15. 00	O O		PHARMACY	15.00	2, 452		4.00
5.00	ADULTS & PEDIATRICS	30. 00	U		ADULTS & PEDIATRICS	30.00	24, 783	0	5. 00
6.00	INTENSIVE CARE UNIT	31. 00	O O		INTENSIVE CARE UNIT	31.00	14, 350	0	6. 00
7.00	SUBPROVI DER - I RF	41. 00	O O		SUBPROVIDER - IRF	41.00	5, 303	0	7. 00
9.00	RADI OLOGY-DI AGNOSTI C	54. 00	O O		RADI OLOGY-DI AGNOSTI C	54.00	4, 442	0	9.00
11.00	LABORATORY	60.00	O O		LABORATORY	60.00	15, 553	0	11.00
12.00	ONCOLOGY	60. 01	O O		ONCOLOGY	60. 01	19, 640	0	12.00
13.00	RESPIRATORY THERAPY	65. 00	O O		RESPIRATORY THERAPY	65.00	9, 721	0	13.00
14.00	PHYSI CAL THERAPY	66. 00	O O		PHYSI CAL THERAPY	66.00	4, 751	0	14.00
17. 00	EMERGENCY	91. 00	O O		EMERGENCY	91.00	11, 974	0	17. 00
18.00	AMBULANCE SERVICES	95. 00	0		AMBULANCE SERVICES	95.00	2, 097	0	18.00
19. 00	MGH PHYS PRACT MGMT	192. 14	0		MGH PHYS PRACT MGMT	192. 14	106	0	19.00
20.00	MGH MARION SURGEONS	192. 15	0		MGH MARION SURGEONS	192. 15	602	0	20.00
21. 00	MGH FMC SOUTH	192. 17	0		MGH FMC SOUTH	192. 17	2, 135	0	21. 00
22. 00	MGH FMC MARION	192. 19	0		MGH FMC MARION	192. 19	1, 078	0	22. 00
23. 00	MGH FMC GAS CITY	193. 02	0		MGH FMC GAS CITY	193. 02	951	0	23. 00
24. 00	MGH MAR FAM PRACT	193. 04	0		MGH MAR FAM PRACT	193. 04	3, 660	0	24. 00
25. 00	LUNG CENTER	192. 12	0		LUNG CENTER	192. 12	607	0	25. 00
26. 00	MGH PEDIATRIC CTR	193. 06	O O		MGH PEDIATRIC CTR	193.06	2, 246	0	26. 00
27. 00	MGH SPECIALTY PHYS	193. 07	O O		MGH SPECIALTY PHYS	193. 07	284	0	27. 00
28. 00	MGH FMC NORTHWOOD	193. 01	O O		MGH FMC NORTHWOOD	193. 01	2, 815	0	28. 00
30. 00	OB/GYN	193. 12			<u>OB/GYN</u>	<u>193</u> . <u>12</u>	135	9	30. 00
	I - NURSERY RECLASS		U	170, 611	<u> </u>		170, 611	U	
1. 00	NURSERY	43. 00	945, 953	121 706	ADULTS & PEDIATRICS	30.00	945, 953	434, 796	1. 00
1.00	0	43.00	945, 953	434, 796		30.00	945, 953	434, 796	1.00
	J - SMMP HOUSEKEEPING	RECLASS	743, 733	434, 770	<u> </u>		743, 733	434, 770	
1. 00	ADMI NI STRATI VE &	5. 00	0	15 821	HOUSEKEEPI NG	9.00	o	72, 038	1. 00
1.00	GENERAL	0.00		10, 021	NOOSEREEL THO	7.00	٩	72,000	1.00
2.00	OPERATION OF PLANT	7. 00	0	1, 633		0.00	0	0	2. 00
3. 00	HOUSEKEEPI NG	9. 00	o	360		0.00	o	0	3. 00
4. 00	DI ETARY	10.00	o	605		0.00	0	0	4. 00
5. 00	MGH FMC SOUTH	192. 17	o	25, 098		0.00	o	0	5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	22, 385		0.00	0	0	6. 00
7. 00	CT SCAN	57. 00	0	1, 563		0.00	0	0	7. 00
8. 00	MAGNETIC RESONANCE	58. 00	0	1, 759		0.00	0	0	8. 00
5. 50	I MAGING (MRI)	33. 33	٦	1, , 5 /		3.00	9		5. 55
9. 00	LABORATORY	60.00	o	<u>2, 8</u> 14		0.00	o	0	9. 00
7. 50	TOTALS	33.00	 -	72, 038	TOTALS — — —	3.00	— — — #		,. 00
	K - LAUNDRY RECLASS	1	<u> </u>	, 2, 000	==		<u> </u>	, 2, 300	
1.00	LAUNDRY & LINEN	8. 00	ol	463, 041	HOUSEKEEPI NG	9.00	0	463, 041	1. 00
	SERVICE						1		
	TOTALS		0	463, 041	TOTALS		0	463, 041	
500.00	Grand Total:		2, 576, 725		Grand Total:		2, 747, 336	9, 280, 977	500.00
	Increases			[[Decreases				

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150011

				T	o 06/30/2016	Date/Time Pre	pared:
						11/23/2016 9:	25 am
			5 .	Acqui si ti ons	-		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	2.00	2.00	4.00	Retirements	
	DADT I ANALYCIC OF CHANCEC IN CADITAL ACCE	1.00	2.00	3. 00	4. 00	5. 00	
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		224 200	0	224 200	0	1 00
1.00	Land	4, 422, 249	224, 300	0	224, 300	0	1.00
2.00	Land Improvements	3, 341, 756	11, 775		11, 775	447.044	2.00
3.00	Buildings and Fixtures	108, 209, 879	5, 845, 416	0	5, 845, 416	147, 914	3. 00
4.00	Building Improvements	871, 325	1, 602, 347	0	1, 602, 347	0	4. 00
5.00	Fi xed Equipment	1, 005, 608		0	0	0	5. 00
6.00	Movable Equipment	77, 858, 280	4, 067, 022	0	4, 067, 022	3, 231, 756	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	195, 709, 097	11, 750, 860	0	11, 750, 860	3, 379, 670	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	195, 709, 097	11, 750, 860	0	11, 750, 860	3, 379, 670	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, 646, 549	0				1. 00
2.00	Land Improvements	3, 353, 531	0				2. 00
3.00	Buildings and Fixtures	113, 907, 381	0				3. 00
4.00	Building Improvements	2, 473, 672	0				4. 00
5.00	Fi xed Equipment	1, 005, 608	0				5. 00
6.00	Movable Equipment	78, 693, 546	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	204, 080, 287	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	204, 080, 287	o				10. 00

Health Financial Systems		MARION GENERAL HOSPITAL			In Lieu of Form CMS-2552-10				
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der	CCN: 150011	Peri od:	Worksheet A-7			
					From 07/01/2015 To 06/30/2016		nared:		
					10 00/30/2010	11/23/2016 9:			
	SUMMARY OF CAPITAL								
					T				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see				
					instructions)	instructions)			
		9. 00	10. 00	11. 00	12. 00	13. 00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	NEW CAP REL COSTS-BLDG & FLXT	12, 625, 875	0		0 0	0	1.00		
3.00	Total (sum of lines 1-2)	12, 625, 875	0		0	0	3. 00		
		SUMMARY O	F CAPITAL		<u> </u>				
	Cost Center Description	0ther	Total (1) (sum						
	·	Capi tal -Relate	of cols. 9						
		d Costs (see	through 14)						
		instructions)	Ů,						
		14. 00	15. 00						
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2									
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12, 625, 875				1. 00		
3.00	Total (sum of lines 1-2)	0	12, 625, 875				3. 00		

Health Financial Systems	MARION GENERAL HOSPITAL			In Lieu of Form CMS-2552-10				
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7			
				From 07/01/2015 To 06/30/2016		nared.		
					11/23/2016 9: 2			
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL			
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance			
		Leases	for Ratio	instructions)				
			(col. 1 - col					
			2)					
	1.00	2. 00	3. 00	4. 00	5. 00			
PART III - RECONCILIATION OF CAPITAL COSTS (1	70 705 00					
1.00 NEW CAP REL COSTS-BLDG & FIXT	72, 735, 296		72, 735, 29			1.00		
3.00 Total (sum of lines 1-2)	72, 735, 296		72, 735, 29	_		3. 00		
	ALLUCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPIT			F CAPITAL			
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease			
		Capi tal -Relate						
		d Costs	through 7)	0.00	40.00			
DART III DECONCILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00			
1.00 NEW CAP REL COSTS-BLDG & FIXT	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
3.00 Total (sum of lines 1-2)	0	0		0 12, 626, 664 0 12, 626, 664		1. 00 3. 00		
3.00 Total (Suil of Titles 1-2)	SUMMARY OF CAPITAL					3.00		
SUMMAN OF CAPTIAL								
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum			
		instructions)	instructions)	Capi tal -Rel ate				
				d Costs (see	through 14)			
	44.00	10.00	10.00	instructions)	45.00			
DART III DECONCILIATION OF CARLTAL COCTO	11. 00	12.00	13.00	14. 00	15. 00			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1 OO NEW CAP REL COSTS-RIDG & FLXT -97 271 0 0 11 393 80								
1.00 NEW CAP REL COSTS-BLDG & FIXT 3.00 Total (sum of lines 1-2)	-97, 271 -97, 271	0		0 0	,,	1. 00 3. 00		
3.00 Total (Suil Of TitleS 1-2)	-91,211	1 0	1	U _I U	11, 393, 801	3.00		

In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: From 07/01/2015 Provider CCN: 150011

					rom 07/01/2015 o 06/30/2016		
				Expense Classification on	Worksheet A	11/23/2016 9:	25 am
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1. 00	I pyostmont i poemo NEW CAD	1.00	2. 00	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00 0	1. 00
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			FIXT	1.00	U	1.00
2. 00	2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		O	cost center bereted	2.00		2.00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		0				
6. 00	Rental of provider space by suppliers (chapter 8)		Ü		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-398, 400			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
12.00	transactions (chapter 10)		0		0.00		12 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-20, 340	CAFETERI A	0. 00 6. 01	0	13. 00 14. 00
15. 00	Rental of quarters to employee		0		0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
	abstracts		0				
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20.00	Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		U		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	,	0		0.00	J	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
20.00	therapy costs in excess of		J		55.55		20.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of						
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			NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2.00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 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
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest		0		0.00	0	33. 00
		<u>'</u>	<u>'</u>				

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 07/01/2015 Date/Time Prepared: Provider CCN: 150011

				To	06/30/2016	Date/Time Prep 11/23/2016 9:	
				Expense Classification on		1172072010 71	
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
33. 01	RETURNED CHECK FEE	1. 00 B	2.00	3. 00 ADMI NI STRATI VE & GENERAL	4. 00 5. 00	5. 00 0	33. 01
33. 01	PHYSICIAN PRIV APPLIC	В		ADMINISTRATIVE & GENERAL	5.00	0	
33. 03	SALE OF MEDICAL RECORDS &	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	ABSTRACTS CHILD SEAT SAFETY INSPECTION	В	-1 613	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	HEALTH SCREENING FEES - LAB	В		LABORATORY	60.00	0	33. 05
33. 06	HEALTH SCREENING FEES - RAD	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 07	MED STAFF OTHER SCREENING-MED STAFF	В	2, 074	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	HEALTH SCREENING FEES	В	-2, 710	LABORATORY	60.00	0	33. 08
33. 09	FLU SHOT HEALTH SCREENS	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10 33. 11	REBATE RENTAL OF PROVIDER SPACE BY	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 10 33. 11
	SUPPLI ER				0.00		
33. 12 33. 13	RENT SPACE UPLAND PAGER RENTAL	B B		LABORATORY ADMI NI STRATI VE & GENERAL	60. 00 5. 00	0	33. 12 33. 13
33. 14	SALE OF SCRAP, WASTE, ETC,	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	SALE OF XRAY FILM	В	·	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 15
33. 16	EMPL UNI FORMS	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17 33. 18	PCC MARKETING AG EDUCATIONAL WORKSHOP	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 17 33. 18
33. 19	OPT HEALTH LINEN SEV	В		LAUNDRY & LINEN SERVICE	8. 00	0	33. 19
33. 20	AMBULANCE SVC - ASSISTS	В		AMBULANCE SERVICES	95. 00	0	33. 20
33. 21	AMBULANCE SVC - CORONER SVC	В		AMBULANCE SERVICES	95.00	0	33. 21
33. 22 33. 23	AMBULANCE SVC - LINEN SERVICES AMBULANCE SVC - COMMUNITY	B B		AMBULANCE SERVICES AMBULANCE SERVICES	95. 00 95. 00	0	33. 22 33. 23
33. 23	EVENT STAF		-740	AWBULANCE SERVICES	73.00	0	33. 23
33. 24	CONTRACT ARU OTH ARU MEDICAL	В	-58, 258	SUBPROVIDER - IRF	41. 00	0	33. 24
33. 25	DI RECTO SCHOOL PHYS OTH SCHOOL PHYS	В	-3.000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	PHLEBOTOMY	В		LABORATORY	60.00	0	33. 26
33. 27	PRECEPT OTHER PHARMACY STUDENT			DRUGS CHARGED TO PATIENTS	73. 00	0	33. 27
33. 28 33. 29	CLINICAL STUDY- OTHER SICK CHILD CARE PROGRAM	B B		ONCOLOGY ADULTS & PEDIATRICS	60. 01 30. 00	0	33. 28 33. 29
33. 30	UNCLAIMED OTHER STATE MONIES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 30
00.04	RECOVER		4 744	ADMINISTRATIVE & SENERAL	F 00		00.04
33. 31	UNCLAIMED OTHER 125 MED/CHILD CARE E	В	-4, /11	ADMINISTRATIVE & GENERAL	5. 00	0	33. 31
33. 32	UNCLAIMED OTHER MONIES RECOVERED	В	-216	ADMINISTRATIVE & GENERAL	5. 00	0	33. 32
33. 33	VENDING MACHINES	В		CAFETERI A	6. 01	0	
33. 34 33. 35	CPR TRAIN OTH AHA COMMUNITY PHYSICIAN RECRUITMENT	B A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	
33. 36	ED ANESTHESI OLOGI ST	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 37	GAIN ON DISPOSAL	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 37
33. 38	TELEVISION AND RADIO SERVICE	A		OPERATION OF PLANT	7. 00	0	33. 38
33. 39 33. 40	TELEPHONE SERVICE TELEPHONE SERVICE	A A		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	33. 39 33. 40
33. 41	MI SC REV	В		ADMI NI STRATI VE & GENERAL	5. 00	Ö	33. 41
33. 42	MI SC REV	В		ONCOLOGY	60. 01	0	33. 42
33. 43 33. 44	ENTERTAL NMENT EXP EMPLOYEE USE OF AUTO	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0 0	33. 43 33. 44
33. 45	DONATI ONS	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	33. 45
33. 46	VHA OPPORTUNI TY	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 46
33. 47	VHA OPPORTUNITY	A		ADMI NI STRATI VE & GENERAL	5.00	0	33. 47
33. 48 33. 49	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	33. 48 33. 49
33. 50	VHA OPPORTUNI TY	A	·	DI ETARY	10. 00	0	33. 50
33. 51	VHA OPPORTUNI TY	A	-932	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 51
33. 52	VHA OPPORTUNITY	A		PHARMACY	15. 00	0	33. 52
33. 53 33. 54	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	33. 53 33. 54
33. 55	VHA OPPORTUNI TY	A		SUBPROVI DER - I RF	41. 00	0	33. 55
33. 56	VHA OPPORTUNI TY	A		OPERATING ROOM	50.00	0	33. 56
33. 57	VHA OPPORTUNITY	A		RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 58 33. 59	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	0	33. 58 33. 59
33. 60	VHA OPPORTUNI TY	A		ONCOLOGY	60. 01	0	33. 60
33. 61	VHA OPPORTUNI TY	Α	-2, 682	RESPIRATORY THERAPY	65. 00	0	33. 61

				To		Date/Time Pre 11/23/2016 9:	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 62	VHA OPPORTUNI TY	A	-93	PHYSI CAL THERAPY	66.00	0	33. 62
33. 63	VHA OPPORTUNI TY	A	-148	ELECTROCARDI OLOGY	69.00	0	33. 63
33. 64	VHA OPPORTUNI TY	A	-5	CARDI AC REHAB	69. 01	0	33. 64
33. 65	VHA OPPORTUNI TY	A	-196	CLINIC	90.00	0	33. 65
33. 66	VHA OPPORTUNI TY	A		EMERGENCY	91. 00	0	33. 66
33. 67	VHA OPPORTUNI TY	A		AMBULANCE SERVICES	95. 00	0	33. 67
33. 68	FINANCE BANK SERVICE CHARGES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 68
33. 69	FINANCE DISCOUNT PAYMENTS	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 69
33. 70	NONALLOWABLE 2008 BONDS	A		NEW CAP REL COSTS-BLDG &	1. 00	11	33. 70
33.70	NONALLOWABLE 2006 BONDS	A	-04, 432	FLXT	1.00	11	33.70
33. 71	BLDG COSTS	A	700	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 71
33.71	BEDG COSTS	A	707	FLXT	1.00	7	33.71
33. 72	ELIMINATING ENTRIES	A	44 421	MGH PHYS PRACT MGMT	192. 14	0	33. 72
		1		MGH WORK SOLUTIONS		0	33. 72
33. 73	ELIMINATING ENTRIES	A		le l	194. 04	Ŭ	
33. 74	ELIMINATING ENTRIES	A		LUNG CENTER	192. 12	0	33. 74
33. 75	ELIMINATING ENTRIES	A		MGH MARI ON SURGEONS	192. 15	0	33. 75
33. 76	ELIMINATING ENTRIES	A		MGH FMC SOUTH	192. 17	0	33. 76
33. 77	ELIMINATING ENTRIES	A	·	MGH FAIRM MED ASSOC	192. 18	0	33. 77
33. 78	ELIMINATING ENTRIES	A		MGH FMC MARION	192. 19	0	33. 78
33. 79	ELIMINATING ENTRIES	A		MGH FMC GAS CITY	193. 02	0	33. 79
33. 80	ELIMINATING ENTRIES	A		MGH FMC SWAYZEE	193. 05	0	33. 80
33. 81	ELIMINATING ENTRIES	A	-89, 847	MGH PEDIATRIC CTR	193. 06	0	33. 81
33. 82	ELIMINATING ENTRIES	A	-42, 576	MGH SPECIALTY PHYS	193. 07	0	33. 82
33.84	LOBBYING COSTS	A	-21, 917	ADMINISTRATIVE & GENERAL	5.00	0	33. 84
33.85	LOBBYING COSTS	A	-317	PHARMACY	15. 00	0	33. 85
33. 86	LOBBYING COSTS	A	-673	ONCOLOGY	60. 01	0	33. 86
33. 87	OPERATING INTEREST INCOME	В	-32, 819	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 87
			,	FLXT			
33. 88	ED ON CALL SVC A/C 7000.2512	A	-2. 338. 803	ADMINISTRATIVE & GENERAL	5. 00	0	33. 88
33. 89	XIX ASSESSMENT FEE A/C	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 89
30.07	7200. 7892	'`	0,000,007		3.00		50.07
33. 90	SELF INSURANCE EXPENSE	A	-1.051 698	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 90
33. 91	PENSION PLAN ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	n	33. 91
50. 00	TOTAL (sum of lines 1 thru 49)	1	-13, 350, 545		4.00	O	50.00
30.00	(Transfer to Worksheet A,		10, 550, 545				30.00
	column 6, line 200.)						
	COTAINIT O, TITLE 200. J						

⁽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.

						10 00/30/2010	11/23/2016 9:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi 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	15, 900	15, 900	0	0	0	1. 00
2.00	69. 00	ELECTROCARDI OLOGY	53, 802	53, 802	2 0	0	0	2. 00
3.00	65.00	RESPI RATORY THERAPY	2, 098	2, 098	3 0	0	0	3. 00
4.00	91.00	EMERGENCY	165, 000	165, 000	o c	0	0	4. 00
5.00	60.00	LABORATORY	11, 600	11, 600	o c	0	0	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	150, 000	150, 000	o c	0	0	6. 00
7.00	0. 00		0	(o c	0	0	7. 00
8.00	0. 00		0	(o c	0	0	8. 00
9.00	0. 00		0	(o c	0	0	9. 00
10.00	0. 00		0	(o c	0	0	10.00
200.00			398, 400	398, 400	ol c		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	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		SUBPROVIDER - IRF	0	1	1	1	0	
2.00		ELECTROCARDI OLOGY	0	() C	0	1	
3.00		RESPI RATORY THERAPY	0	() C	0	0	
4. 00		EMERGENCY	0	() C	0	0	
5.00		LABORATORY	0	() C	0	0	
6. 00		RADI OLOGY-DI AGNOSTI C	0	() C	0	0	0.00
7. 00	0. 00		0	() C	0	0	
8. 00	0. 00		0	() C	0	0	0.00
9. 00	0. 00		0	() C	0	0	
10. 00	0. 00		0	() C	0		1
200.00			0	(0		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00	0.00	14	1/ 00	47.00	40.00		
1 00	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		4 00
1.00		SUBPROVI DER - I RF	0		1			1.00
2.00		ELECTROCARDI OLOGY	0	1	1	00,002		2.00
3.00		RESPIRATORY THERAPY	0	(2, 098	•	3. 00
4.00		EMERGENCY	0			165,000		4. 00
5.00		LABORATORY	0			11, 600		5. 00
6.00		RADI OLOGY-DI AGNOSTI C				150, 000		6. 00
7.00	0.00]		1		7. 00
8.00	0.00					1		8. 00
9.00	0.00		0	(1	_		9. 00
10.00	0. 00		0	1	1			10.00
200.00			0) () c	398, 400	1	200. 00

		ncial Systems	MARION GENER				eu of Form CMS-	<u> 2552-10</u>
COST A	ALLOCA	TION - GENERAL SERVICE COSTS		Provi der	CCN: 150011 P	eriod: rom 07/01/2015	Worksheet B Part I	
					Т		Date/Time Pre	
				CAPITAL			11/23/2016 9:	25 am
				RELATED COSTS				
		Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
			for Cost Allocation	FIXT	BENEFITS DEPARTMENT		& GENERAL	
			(from Wkst A		DEI / IKT III EI ITT			
			col . 7)					
	CENER	RAL SERVICE COST CENTERS	0	1.00	4. 00	4A	5. 00	
1.00		NEW CAP REL COSTS-BLDG & FLXT	11, 393, 801	11, 393, 801				1.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	19, 612, 106	1				4. 00
5.00		ADMINISTRATIVE & GENERAL	20, 346, 251	1, 888, 255	3, 630, 756	25, 865, 262		
6. 00 6. 01		MAINTENANCE & REPAIRS CAFETERIA	1, 419, 475	150, 926		1, 570, 401	0 325, 819	
6. 02	1	CAFETERI A	0,417,475	0	ő	0	0	1
7.00		OPERATION OF PLANT	5, 172, 580	2, 940, 088	260, 319	8, 372, 987	1, 737, 185	
8.00		LAUNDRY & LINEN SERVICE	458, 915	1	1	,		1
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	2, 530, 394 515, 975	1	1	2, 632, 694 724, 565		1
13. 00		NURSING ADMINISTRATION	1, 005, 624	1				1
14. 00	01400	CENTRAL SERVICES & SUPPLY	526, 168	1	1			1
15. 00		PHARMACY	5, 607, 318	95, 225	1, 062, 666	6, 765, 209	1, 403, 612	15. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	7, 062, 306	1, 346, 612	2, 937, 861	11, 346, 779	2, 354, 173	30.00
31. 00		INTENSIVE CARE UNIT	2, 676, 011	1	1			1
40. 00		SUBPROVIDER - IPF	0	i .	0	0	0	1
41.00		SUBPROVIDER - IRF	1, 682, 232	298, 766	435, 461	2, 416, 459	1	1
42. 00 43. 00		SUBPROVI DER NURSERY	1, 380, 749	0	0 424, 355	0 1, 805, 104	0 374, 514	1 00
43.00		LARY SERVICE COST CENTERS	1, 380, 747	1 0	424, 355	1, 803, 104	374, 314	43.00
50.00		OPERATING ROOM	12, 708, 850	1, 077, 863	0	13, 786, 713	2, 860, 457	50.00
51.00		RECOVERY ROOM	0	0	0	0	0	
54. 00 57. 00		RADI OLOGY-DI AGNOSTI C CT SCAN	4, 680, 399 843, 365	1			1, 324, 041 224, 323	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	453, 980				126, 359	
59.00		CARDI AC CATHETERI ZATI ON	2, 166, 624		1			
60. 00		LABORATORY	6, 776, 004	1				1
60. 01 60. 02		ONCOLOGY RADIATION ONCOLOGY	1, 556, 976	0	427, 712	1, 984, 688	411, 773 0	1
65. 00		RESPI RATORY THERAPY	1, 905, 775	143, 164	552, 628	2, 601, 567		
66. 00		PHYSI CAL THERAPY	2, 048, 466	1				1
69. 00		ELECTROCARDI OLOGY	858, 275	1				
69. 01 71. 00		CARDIAC REHAB MEDICAL SUPPLIES CHARGED TO PATIENTS	142, 510	40, 428	1		49, 399 0	1
71.00		IMPL. DEV. CHARGED TO PATIENTS			0		0	1
73. 00		DRUGS CHARGED TO PATIENTS	4, 050, 711	Ö	Ö			1
	OUTPA	ATIENT SERVICE COST CENTERS						
		CLINIC EMERGENCY	425, 302					
91. 00 92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART)	4, 687, 706	345, 552	1, 747, 640	6, 781, 098 0	1, 406, 908	91.00
92. 01		OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	
		R REIMBURSABLE COST CENTERS		1	1			
95. 00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	1, 117, 866	129, 450	470, 636	1, 717, 952	356, 432	95. 00
113.00		INTEREST EXPENSE			1			113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	125, 812, 714	11, 341, 155	17, 390, 309	123, 104, 102	20, 174, 686	118. 00
400.00		I MBURSABLE COST CENTERS	10.10/	11.00/	1 11 710			
		OGIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	43, 106	1	11, 743 0			190. 00 192. 00
		VISITOR MEALS		Ö	Ö	0		192. 02
		GREAT BEGINNINGS/MATERNAL	110, 632	. 0	47, 813	158, 445		192. 03
		LIFELINE	0	0	0	0		192. 04
		OWNED PROPERTIES PARISH NURSING	88, 836 57, 575		0 17, 406	88, 836 85, 641		192. 05 192. 08
		BIOTERRORISM GRANT	56, 482	1	13, 712			192. 09
		BREAST PUMPS	0	Ö	0			192. 10
		LUNG CENTER	551, 473	1	45, 410			1
		MGH PHYS PRACT MGMT MGH MARION SURGEONS	1, 431, 798		415, 322			1
		MGH MGH MED ONC	2, 388, 448 1, 307, 729		207, 386 186			
		MGH FMC SOUTH	3, 095, 396	l e	349, 783			1
		MGH FAIRM MED ASSOC	81, 044	1	2, 430	83, 474	17, 319	192. 18
		MGH FMC MARION NONPAID WORKERS	714, 679	0	101, 167 0			192. 19 193. 00
		NONPALD WORKERS	971, 370					1
		MGH FMC GAS CITY	534, 189		68, 522			
193. 03	19303	MGH HOSPITALISTS	3, 042, 405	0			638, 145	193. 03

Peri od: Worksheet B
From 07/01/2015 Part I
To 04/20/2014 Part II
To 04/2014 Part II
To 04/2014 Part II
To 04/2014 Part II
To 04/201 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150011

				o 06/30/2016	Date/Time Prepared: 11/23/2016 9:25 am
		CAPI TAL			
		RELATED COSTS			
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE
	for Cost	FLXT	BENEFITS		& GENERAL
	Allocation		DEPARTMENT		
	(from Wkst A				
	col. 7)	1, 00	4.00	4A	5. 00
193.04 19304 MGH MAR FAM PRACT			335, 888		
193.05 19305 MGH FMC SWAYZEE	2, 808, 045 216, 710				
	1	0	32, 849		
193. 06 19306 MGH PEDIATRIC CTR 193. 07 19307 MGH SPECIALTY PHYS	1, 274, 804	0	120, 951		
193.08/1930/MGH FMC CONVERSE	346, 105 294, 553		34, 729 48, 646		
193.09 19309 MGH UPLAND HEALTH	1				
193. 10 19310 MGH MGH WOMENS CTR	1, 436, 883	0	163, 855	1, 600, 738	0 193. 10
193. 10 19310 MGH MGH PSYCHLATRY	0	0		0	0 193.10
193. 11 19311 MGH MGH PSTCHTATRT	2, 220, 255	0	194, 014	2, 414, 269	
193. 15 19315 MGH RIVER VIEW BLDG	2, 220, 233	0	194, 012	2,414,209	0 193. 15
194. 00 07963 OTHER NONREI MBURSABLE	0	0			0 193.15
194. 01 07963 OTHER NONRET MBURSABLE	0	0		0	0 194.00
194.02 07951 MENTAL HEALTH		0			0 194.01
194. 03 07952 ADVERTI SI NG	314, 811	0	100, 058	414, 869	
194. 04 07953 MGH WORK SOLUTIONS	744, 403	0	162, 490	1	
194. 05 07954 MGH TAYLOR UNI VERSI TY	150, 980		23, 183		
194. 08 07957 MGH SMMP BLDG	289, 770		25, 100	289, 770	
194. 09 07958 MGH AMBUCARE BLDG	53, 441			53, 441	11, 088 194. 09
194. 10 07959 MGH 106 LYONS BLDG	4, 708			4, 708	
194. 11 07960 FAI RMOUNT	14, 913			14, 913	
194. 12 07961 GAS CLTY	57, 067	0		57, 067	
194. 13 07962 LYONS	16, 051	0		16, 051	3, 330 194. 13
194. 14 07964 WABASH	495			495	
200.00 Cross Foot Adjustments	473			1	200.00
201.00 Negative Cost Centers		0	1	0	0 201.00
202.00 TOTAL (sum lines 118-201)	150, 531, 870	11, 393, 801	20, 046, 275	150, 531, 870	

Provider CCN: 150011

COST CONTON DESCRIPTION FORESAME SERVICE DIST CHIPTES						00/30/2010	11/23/2016 9:	
		Cost Center Description		CAFETERI A	CAFETERI A			
CEMENT STROTC OST CENT ESS 1, 00 MIDOLO PRICE OST END TO STROTC 1, 00 MIDOLO PRICE OST END				6 01	6.02			
1.00 00000 MARY CAP HEL COSTS-BLIDG A FIXT		GENERAL SERVICE COST CENTERS	0.00	0.01	0.02	7.00	8.00	
5.00	1.00							1. 00
0.000 0.000 INTERIMENT		1 I						
6. 01 0.0001 GAFTERIA 0 1.896.220 0.0007 GAFTERIA 0 1.894.541 1.804.5451 1.804.5		1	_					
0.002 ORGOZ CAFETERIA		l	0	4 007 000				
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000			0		1 004 541			
B. OD ORDON CAMPANY & LINEN STEWLEY D. O. D. D. O. D.			0	1, 824, 541		10 154 280		
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000000		l	0	0	44, 100		745 577	
10.00 OTODO DIT TARY 0		l	0	Ö	0			
14.00 01400 PARMARCY 0 0 12.936 110.686 0 15.00 15		l	0	0	0			
	13.00	01300 NURSING ADMINISTRATION	0	0	27, 187	1	0	13. 00
Impart Into Routine Service Cost Centers 0	14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	12, 936	126, 173	8, 396	14. 00
30 00 3000 ADULTS & PEDIATRICS 0 0 328, 713 2, 286, 461 177, 782 30 00	15. 00		0	0	78, 895	161, 686	0	15. 00
31 00 03100 INTERIST WE CARE UNIT 0 0 0 110, 061 529, 778 45, 766 31 0.0	00.00			٥	200 740	0.007.474	477 700	00.00
40.00 04000 04000 04000 040		1	1	- 1				
41.00 04100 SUBPROVIDER - 1 NF		1 I	0	ı,	110,001	529, 776	•	
42.00 04.200 SUBPROYI DER 0 0 0 0 0 0 0 0 0		1 I	0	0	49 741	507 285		
MICH LARY SERVICE COST CENTERS		l I	0	o	0	0		
50.00 0500000 050000 050000 050000 050000 050000 050000 0500000 0500000 050000 050000 050000 050000 050000 050000 0500000 050000 050000 050000 050000 050000 050000 0500000 0500000 0500000 0500000 0500000 0500000 05000000 05000000 05000000 050000000 0500000000	43.00	04300 NURSERY	0	0	43, 358	o	0	43. 00
151 00								
54.00 05400 RADIO LOCY-DIACMOSTIC 0 0 124, 618 1,094,805 66, 640 54 05 05 05 05 05 05		l I	1	-		1, 830, 144	•	
17.00		1 I	0	ı,	-	1 004 005		
SB 00 OSBOON DAGNETI C RESONANCE L MAGIN (NRT) 0 0 12,088 204,418 0 88,00		1 I	0	0				
59 0.0 05900 CARDIAL CATHETER ZATION 0 0 26,968 266,742 19,728 59 0.0		1 I	0	0				
60. 00			0	0				
60.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000			o	o				
66.00 06500 PASSION THERAPY 0 0 55,620 243,084 2,732 65.00 69.00 06900 PASSION THERAPY 0 0 0 37,903 446,627 24,815 66.00 69.01 06901 CARDIA CE REHAB 0 0 0 0 42,879 420,965 4,810 69.00 71.00 07100 OT100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73.00 73.00 07300 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73.00 73.00 07300 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	60. 01	06001 ONCOLOGY	0	0	0	o	0	60. 01
66.00 06600 PHYSI CAL THERAPY 0 0 0 37, 903 46, 627 24, 815 66, 00 0 0 0 0 0 10, 900 10,	60. 02		0	0	0	0	0	60. 02
69.00 0.00		l	0	0				
69 01 06901 CARDIAC REHAB 0 0 6,426 68,644 0 69, 01		1	0	0				
77. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l	0	0				
72.00 07.200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 73.00 74.00 74.00 74.00 74.00 74.00 75			0	0	0, 420 0	08, 044		
73.00 073.00 DO 0 0 0 0 0 0 0 0 0			-	-	0	0		
OUTPATT ENT SERVICE COST CENTERS O			1	- 1	0	o	-	
91.00 09100 EBRERCENCY 92.00 9								
92. 00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 00 92. 01 09201 095ERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 92. 00 92. 01 095EV 09500 095EV 09500 095EV 09500 095EV 095EV			1	-		· · · · · · · · · · · · · · · · · · ·		
92.01 09201 09201 085ERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 92.01			0	0	196, 907	586, 726	187, 720	
OTHER REI MBURSABLE COST CENTERS OSOO AMBULANCE SERVICES OSOO AMBULANCE SERVICES OSOO AMBULANCE SERVICES OSOO OSOO AMBULANCE SERVICES OSOO OSOO AMBULANCE SERVICES OSOO				0	0		0	
95.00 09500 AMBULANCE SERVICES 0 0 68, 159 219, 797 38, 676 95.00 SPECIAL PURPOSE COST CENTERS 113.00 I NTEREST EXPENSE 113.00 I NONNEI MURRSABLE COST CENTERS 113.00 I NONNEI MURRSABLE COST CENTER I NURSI NU	92.01		l o	<u> </u>	U	U U	0	92.01
113.00 11300 INTEREST EXPENSE	95. 00		0	0	68, 159	219. 797	38, 676	95. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 1,824,541 1,655,095 10,064,890 745,448 118.00			-1		337.131		22/212	
NONRE MBURSABLE COST CENTERS 190.00 190.	113.00							
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 1, 115 71, 290 0 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 192. 10 1	118.00		0	1, 824, 541	1, 655, 095	10, 064, 890	745, 448	118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00 192. 02 19202 VI SI TOR MEALS 0 0 71, 679 0 0 0 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 192. 04 19204 LI FELI NE 0 0 0 0 0 192. 05 19205 OWNED PROPERTI ES 0 0 0 0 0 192. 08 19211 PARTS IS NURSI NG 0 0 0 0 192. 09 19212 BI OTERRORI SM GRANT 0 0 0 0 192. 10 19214 BREAST PUMPS 0 0 0 0 192. 10 19214 BREAST PUMPS 0 0 0 0 192. 11 19209 LUNG CENTER 0 0 0 0 192. 12 19209 LUNG CENTER 0 0 0 0 192. 15 19215 MGH MARI ON SURGEONS 0 0 0 0 192. 16 19216 MGH MED ONC 0 0 0 192. 17 19217 MGH FMC SOUTH 0 0 0 192. 18 19218 MGH FAIR MED ASSOC 0 0 0 193. 01 19301 MGH FMC MARION 0 0 193. 02 19302 MGH FMC MARION 0 0 0 193. 03 19303 MGH FMC NORTHWOOD 0 0 0 193. 04 19304 MGH FME CASC LTY 0 0 0 193. 05 19305 MGH FMC SWAYZEE 0 0 0 193. 06 19306 MGH FME DIATRIC CTR 0 0 0 193. 07 19307 MGH FME DEI ATRIC CTR 0 0 0 193. 07 19307 MGH FECI ALTY PHYS 0 0 0 192. 17 193. 07 19307 MGH FECI ALTY PHYS 0 0 0 193. 07 19307 MGH FECI ALTY PHYS 0 0 0 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY PHYS 0 0 0 193. 07 19307 MGH FECI ALTY PHYS 0 0 0 193. 07 19307 MGH FECI ALTY PHYS 0 0 0 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY PHYS 0 0 193. 07 193. 07 19307 MGH FECI ALTY P	400.00	NONREI MBURSABLE COST CENTERS	1 0	ما	4 445	74 000		100 00
192. 02 19202 VISITOR MEALS 192. 03 19203 GREAT BEGINNINGS/MATERNAL 0 0 0 0 0 0 0 0 192. 03 19203 GREAT BEGINNINGS/MATERNAL 0 0 0 0 0 0 0 0 192. 04 192. 04 19204 LIFELINE 0 0 0 0 0 0 0 0 0 192. 04 192. 04 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 05 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 05 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 08 19211 PARISH NURSING 0 0 0 0 0 0 0 192. 08 192. 09 19212 BIOTERRORISM GRANT 0 0 0 0 0 0 0 192. 09 192. 09 192. 19 18, 100 0 192. 09 192. 10 192. 14 192. 10 192. 14 192. 10 192. 14 192. 10 192. 14 192. 10 192. 14 192. 10 MGH PHYS PRACT MGMT 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	0	1, 115	/1, 290		
192. 03 19203 GREAT BEGINNINGS/MATERNAL 0 0 0 0 0 0 192. 03 192. 04 19204 LIFELINE 0 0 0 0 0 0 0 192. 05 192. 05 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 05 192. 08 19211 PARI SH NURSING 0 0 0 0 0 0 0 192. 05 192. 09 19212 BIOTERRORI SM GRANT 0 0 0 0 0 0 0 0 192. 09 192. 10 19214 BREAST PUMPS 0 0 0 0 0 0 0 0 192. 10 192. 12 19209 LUNG CENTER 0 0 0 8, 913 0 0 192. 12 192. 14 19210 MGH PHYS PRACT MGMT 0 0 0 63, 247 0 0 192. 14 192. 15 19215 MGH MARI ON SURGEONS 0 0 0 0 0 0 192. 15 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 0 0 192. 16 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 0 0 0 192. 17 192. 18 19218 MGH FMC SOUTH 0 0 0 0 0 0 0 0 192. 18 193. 01 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 192. 19 193. 02 19302 MGH FMC NORTHWOOD 0 0 0 0 0 0 0 193. 01 193. 01 19303 MGH HOSPITALISTS 0 0 0 0 0 0 0 0 193. 02 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 23, 787 0 0 193. 06 193. 06 19306 MGH PEDIATRIC CTR 0 0 0 0 23, 787 0 0 193. 06 193. 06 19307 MGH SPECIALTY PHYS			0	71 679	0	0		
192. 04 1920 4 19204 LI FELI NE 192. 05 19205 OWNED PROPERTIES 0 0 0 0 0 0 0 192. 05 192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 0 0 0 0 0 0 0 0 0 192. 09 192. 10 19214 BREAST PUMPS 0 0 0 0 0 0 0 0 0 192. 10 192. 12 19209 LUNG CENTER 0 0 0 8, 913 0 0 192. 12 192. 14 19210 MGH PHYS PRACT MGMT 0 0 0 63, 247 0 0 192. 12 192. 15 19215 MGH MARI ON SURGEONS 0 0 0 0 0 0 0 0 192. 15 192. 16 19216 MGH MGH MED ONC 0 0 0 0 0 0 0 0 192. 16 192. 17 19217 MGH FAI RM MED ASSOC 0 0 0 0 0 0 0 192. 17 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 0 193. 01 193. 01 19301 MGH FMC CAS CI TY 0 0 0 0 0 0 0 0 0 0 193. 02 193. 02 19302 MGH FMC GAS CI TY 0 0 0 0 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 23, 787 0 0 193. 05 193. 06 19306 MGH PEDIATRIC CTR 0 0 0 23, 787 0 0 193. 07 193. 07 19307 MGH SPECIALTY PHYS			o o	, , , , ,	0	ol		
192. 08 19211 PARI SH NURSI NG 192. 09 19212 B OTERRORI SM GRANT 0 0 0 0 0 0 192. 09 192. 10 19214 B OTERRORI SM GRANT 0 0 0 0 0 0 192. 09 192. 12 19209 LUNG CENTER 0 0 0 8, 913 0 0 192. 12 192. 14 19210 MGH PHYS PRACT MGMT 0 0 0 35, 134 0 0 192. 15 192. 16 19215 MGH MGH MED ONC 0 0 0 0 0 129. 15 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 129. 15 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 0 192. 18 192. 19 19219 MGH FMC MARI ON 0 0 0 192. 18 192. 19 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19300 MGH FMC NORTHWOOD 0 0 0 193. 00 193. 02 19302 MGH FMC RAS CITY 0 0 0 0 0 193. 03 193. 03 19303 MGH HOSPITALISTS 0 0 0 23, 787 0 0 193. 06 193. 07 19307 MGH SPECIALTY PHYS	192. 04	19204 LI FELI NE	0	0	0	О		
192. 09 19212 BI OTERRORI SM GRANT 0 0 0 0 0 0 192. 09 192. 10 19214 BREAST PUMPS 0 0 0 0 0 0 192. 10 192. 11 19209 LUNG CENTER 0 0 0 8, 913 0 0 192. 12 192. 14 19210 MGH PHYS PRACT MGMT 0 0 63, 247 0 0 192. 14 192. 15 19215 MGH MARI ON SURGEONS 0 0 0 35, 134 0 0 192. 15 192. 16 192. 16 192. 16 192. 16 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 129 192. 17 192. 18 192. 18 192. 18 MGH FAIRM MED ASSOC 0 0 0 0 0 192. 18 192. 19 19219 MGH FMC MARI ON 0 0 0 192. 18 192. 19 19219 MGH FMC MARI ON 0 0 0 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 01 193.			0	0	0	0		
192. 10 19214 BREAST PUMPS 192. 12 19209 LUNG CENTER 0 0 0 8, 913 0 0 192. 12 192. 14 19210 MGH PHYS PRACT MGMT 0 0 63, 247 0 0 192. 14 192. 15 19215 MGH MARI ON SURGEONS 0 0 0 35, 134 0 0 192. 15 192. 16 19216 MGH MGH MED ONC 0 0 0 0 0 0 0 0 192. 16 192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAIRM MED ASSOC 0 0 0 0 192. 18 192. 19 19219 MGH FMC MARI ON 0 0 0 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 01 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPITALI STS 0 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 23, 787 0 0 193. 06 193. 07 19307 MGH SPECIALTY PHYS 0 0 0 5, 787 0 0 193. 07			0	0	2, 319	18, 100		
192. 12 19209 LUNG CENTER 192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARI ON SURGEONS 192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SUUTH 192. 18 19218 MGH FAI RM MED ASSOC 193. 00 19300 NONPAI D WORKERS 193. 01 19301 NGH FMC SOLITY 194. 01 19300 MGH MGH MGH MGH MGH MGH 195. 02 19302 MGH FMC GAS CI TY 196. 03 19303 MGH HOSPI TALI STS 196. 04 19304 MGH MAR FAM PRACT 197. 05 19305 MGH FMC SWAYZEE 197. 07 19307 MGH SPECI ALTY PHYS 197. 07 19307 MGH SPECI ALTY PHYS 198. 07 19307 MGH SPECI ALTY PHYS 199. 07 19307 MGH SPECI ALTY PHYS 199. 07 19307 MGH SPECI ALTY PHYS 199. 08 19307 MGH SPECI ALTY PHYS 199. 09 193. 07 19307 MGH SPECI ALTY PHYS 199. 09 193. 07 19307 MGH SPECI ALTY PHYS 199. 09 193. 07 19307 MGH SPECI ALTY PHYS 199. 09 193. 07 19307 MGH SPECI ALTY PHYS 199. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS 190. 09 193. 07 19307 MGH SPECI ALTY PHYS			0	0	0	0		
192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARI ON SURGEONS 192. 16 19216 MGH MGH MGH MED ONC 0 0 0 0 0 0 0 0 192. 15 192. 16 19217 MGH FMC SOUTH 0 0 0 0 0 129 192. 17 192. 18 19218 MGH FMC SOUTH 0 0 0 0 0 0 129 192. 17 192. 18 19218 MGH FMC MARI ON 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH HOSPI TALI STS 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 0 0 0 23, 787 0 0 193. 06 193. 07 19307 MGH SPECI ALTY PHYS		l	0	0	0.012	0		
192. 15 19215 MGH MARI ON SURGEONS 192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAIRM MED ASSOC 192. 19 19219 MGH FAIRM MED ASSOC 193. 01 19300 NONPAI D WORKERS 193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH HOSPI TALISTS 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDI ATRI C CTR 193. 07 19307 MGH SPECIALTY PHYS 10 0 0 0 0 193. 05 193. 07 19307 MGH SPECIALTY PHYS 10 0 0 0 0 0 193. 05 193. 07 19307 MGH SPECIALTY PHYS 10 0 0 0 0 0 193. 07		l	0	0		0		
192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH 0 0 0 0 0 0 129 192. 17 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 0 192. 18 192. 19 19219 MGH FMC MARI ON 0 0 0 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 0 0 0 193. 01 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPI TALI STS 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 193. 04 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDI ATRI C CTR 0 0 5,787 0 0 193. 07			0	0		Ö		
192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0 0 129 192. 18 192. 19 19219 MGH FMC MARI ON 193. 00 193.00 193.00 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 0 193. 01 193. 03 19303 MGH HOSPI TALI STS 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDI ATRI C CTR 0 0 0 5,787 0 0 193. 07		l	0	o	0	o		
192. 19 19219 MGH FMC MARI ON 0 0 19, 155 0 0 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 0 0 0 0 0 193. 01 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPI TALI STS 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 193. 04 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDI ATRI C CTR 0 0 23, 787 0 0 193. 06 193. 07 19307 MGH SPECI ALTY PHYS 0 0 5, 787 0 0 193. 07	192. 17	19217 MGH FMC SOUTH	0	0	0	o	129	192. 17
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPI TALI STS 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 193. 03 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDI ATRI C CTR 0 0 23, 787 0 0 193. 07 193. 07 19307 MGH SPECI ALTY PHYS			0	0	0	o		
193. 01 19301 MGH FMC NORTHWOOD 0 0 0 0 193. 01 193. 02 19302 MGH FMC GAS CLTY 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPI TALISTS 0 0 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 193. 04 193. 05 19305 MGH FMC SWAYZEE 0 0 0 0 0 193. 05 193. 06 19306 MGH PEDI ATRI C CTR 0 0 23, 787 0 0 193. 06 193. 07 19307 MGH SPECI ALTY PHYS 0 0 5, 787 0 0 193. 07			0	0	19, 155	0		
193. 02 19302 MGH FMC GAS CITY 0 0 0 0 0 193. 02 193. 03 19303 MGH HOSPITALISTS 0 0 0 0 0 193. 03 193. 04 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 0 193. 04 193. 05 193.05 MGH FMC SWAYZEE 0 0 0 0 0 0 193. 05 193. 06 193. 06 193.07 MGH SPECIALTY PHYS 0 0 5,787 0 0 193. 07			0	0	0	0		
193. 03 19303 MGH HOSPITALISTS 0 0 0 0 0 193. 03 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 0 193. 04 193. 05 193.05 MGH FMC SWAYZEE 0 0 0 0 0 0 193. 05 193. 06 193. 06 193.07 MGH SPECIALTY PHYS 0 0 5,787 0 0 193. 07		1 I	0	0	0	0		
193. 04 193.04 MGH MAR FAM PRACT 0 0 0 0 193. 04 193. 05 193.05 MGH FMC SWAYZEE 0 0 0 0 0 193. 05 193. 06 193.06 MGH PEDLATRIC CTR 0 0 23, 787 0 0 193. 06 193. 07 19307 MGH SPECIALTY PHYS 0 0 5, 787 0 0 193. 07		1 I		0	0	0		
193. 05 193.05 MGH FMC SWAYZEE 0 0 0 0 193.05 193. 06 193.07 MGH PEDIATRIC CTR 0 0 23,787 0 0 193.06 193. 07 19307 MGH SPECIALTY PHYS 0 0 5,787 0 0 193.07				0	0	0		
193. 06 19306 MGH PEDIATRIC CTR 0 0 23, 787 0 0 193. 06 193. 07 19307 MGH SPECIALTY PHYS 0 0 5, 787 0 0 193. 07				o	0	o		
			0	0	23, 787	o		
193. 08 19308 MGH FMC CONVERSE 0 0 0 0 0 193. 08			0	o		o		
	193. 08	19308 MGH FMC CONVERSE	0	0	0	0	0	193. 08

| Peri od: | Worksheet B | From 07/01/2015 | Part | To 06/30/2016 | Date/Time Prepared: | 11/23/2016 9: 25 am

					<u> 11/23/2016 9:</u>	<u>25 am</u>
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6. 01	6. 02	7. 00	8. 00	
193. 09 19309 MGH UPLAND HEALTH	0	0	0	0	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	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	9, 989	0	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	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	0	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194. 10
194. 11 07960 FAI RMOUNT	0	0	0	0	0	194. 11
194. 12 07961 GAS CLTY	0	0	0	0	0	194. 12
194. 13 07962 LYONS	0	0	0	0	0	194. 13
194. 14 07964 WABASH	0	0	0	0	0	194. 14
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, 896, 220	1, 824, 541	10, 154, 280	745, 577	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2015 | Part |
| To 06/30/2016 | Date/Time Prepared: | 11/23/2016 9: 25 am Provider CCN: 150011

			10	06/30/2016	11/23/2016 9:	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
ASSUEDAN ASSUMAS ARRESTS	9.00	10. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
						1
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 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9.00 00900 HOUSEKEEPI NG	2 240 012					9.00
	3, 360, 812	1 207 220				•
10. 00 01000 DI ETARY 13. 00 01300 NURSI NG ADMI NI STRATI ON	45, 842	1, 287, 230				10. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	14, 326 71, 629	0	0 1, 011, 303	1, 029, 310		14.00
15. 00 01500 PHARMACY	45, 842	0		1, 029, 310	8, 455, 244	15.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	43, 642		y U	<u> </u>	0, 400, 244	15.00
30. 00 03000 ADULTS & PEDI ATRI CS	664, 714	732, 257	489, 454	262, 476	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	183, 369	155, 968		102, 931	0	31.00
40. 00 04000 SUBPROVI DER - PF	103, 307	133, 700	103, 07 7	102, 931	0	40.00
41. 00 04100 SUBPROVI DER - RF	160, 448	124, 238	ή "Ι	20, 586	0	41.00
42. 00 04200 SUBPROVI DER	0	124, 230	74,004	20, 300	0	42.00
43. 00 04300 NURSERY	0	0	64, 559	0	0	43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1 04, 337	<u> </u>		45.00
50. 00 05000 OPERATING ROOM	469, 883	0	337, 639	176, 527	0	50.00
51. 00 05100 RECOVERY ROOM	407, 005	0	337,037	170, 327	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	143, 257	0		20, 586	0	54.00
57. 00 05700 CT SCAN	8, 595	0		20, 000	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0, 0,0	0		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	57, 303	0	40, 154	30, 879	0	59.00
60. 00 06000 LABORATORY	160, 448	0	0	61, 759	0	60.00
60. 01 06001 ONCOLOGY	0	0		2, 573	0	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		2, 3, 0	0	60. 02
65. 00 06500 RESPIRATORY THERAPY	120, 336	0	90, 462	56, 612	0	65.00
66. 00 06600 PHYSI CAL THERAPY	120, 330	0	56, 437	30, 012	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	77, 359	0	63, 846	15, 440	0	69.00
69. 01 06901 CARDI AC REHAB	85, 954	0	9, 569	10, 110	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	00,701	0	7, 557	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	8, 455, 244	73. 00
OUTPATIENT SERVICE COST CENTERS			-1	-1	27 1227 = 11	
90. 00 09000 CLI NI C	57, 303	O	18, 009	0	0	90.00
91. 00 09100 EMERGENCY	641, 792	11, 486	293, 193	113, 224	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1					92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	o	0	o	o	0	92. 01
OTHER REIMBURSABLE COST CENTERS				,		
95. 00 09500 AMBULANCE SERVICES	20, 056	O	101, 488	10, 293	0	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 028, 456	1, 023, 949	1, 802, 753	873, 886	8, 455, 244	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 730	O	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
192.02 19202 VISITOR MEALS	0	0	0	О		192. 02
192.03 19203 GREAT BEGINNINGS/MATERNAL	0	0	8, 630	0		192. 03
192. 04 19204 LI FELI NE	0	0	0	0		192. 04
192.05 19205 OWNED PROPERTIES	183, 369	0	0	0		192. 05
192.08 19211 PARISH NURSING	5, 730	0	0	0		192. 08
192.09 19212 BIOTERRORISM GRANT	0	0	0	0		192. 09
192.10 19214 BREAST PUMPS	0	0	0	0		192. 10
192. 12 19209 LUNG CENTER	0	0	0	0	0	192. 12
192.14 19210 MGH PHYS PRACT MGMT	22, 921	0	0	0		192. 14
192.15 19215 MGH MARION SURGEONS	0	0	0	29, 335	0	192. 15
192.16 19216 MGH MGH MED ONC	0	0	0	0		192. 16
192.17 19217 MGH FMC SOUTH	114, 606	0	0	20, 586		192. 17
192.18 19218 MGH FALRM MED ASSOC	0	0	0	0		192. 18
192.19 19219 MGH FMC MARION	0	0	0	20, 586		192. 19
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193.01 19301 MGH FMC NORTHWOOD	0	0	0	2, 573		193. 01
193.02 19302 MGH FMC GAS CLTY	0	0	0	15, 440		193. 02
193. 03 19303 MGH HOSPI TALI STS	0	0	0	0		193. 03
193.04 19304 MGH MAR FAM PRACT	0	0	0	30, 879		193. 04
193.05 19305 MGH FMC SWAYZEE	0	0	0	2, 573		193. 05
193. 06 19306 MGH PEDIATRIC CTR		0	0	2, 573		193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	0	0	0	0	193. 07

| Peri od: | Worksheet B | From 07/01/2015 | Part | | To 06/30/2016 | Date/Time Prepared: |

				00/30/2010	11/23/2016 9:	
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. 08 19308 MGH FMC CONVERSE	0	0	0	2, 573	-	193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	0	23, 159	-	193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0		193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	193. 11
193. 12 19312 OB/GYN	0	0	0	0		193. 12
193. 15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
194.00 07963 OTHER NONREI MBURSABLE	0	0	0	0	0	194. 00
194. 01 07950 MOW	0	135, 003	0	0	0	194. 01
194. 02 07951 MENTAL HEALTH	0	128, 278	0	0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	0	0	0	194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	0	0	5, 147	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	0	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194. 10
194. 11 07960 FAI RMOUNT	0	0	0	0	0	194. 11
194. 12 07961 GAS CITY	0	0	0	0	0	194. 12
194. 13 07962 LYONS	0	0	0	0	0	194. 13
194. 14 07964 WABASH	0	0	0	0	0	194. 14
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, 360, 812	1, 287, 230	1, 811, 383	1, 029, 310	8, 455, 244	202. 00

| Peri od: | Worksheet B | From 07/01/2015 | Part I | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150011

					To 06/30/2016 Date/Time Pr	
	Cost Center Description	Subtotal	Intern &	Total	11/23/2016 9	: 25 aiii
	<u>'</u>		Residents Cost			
			& Post Stepdown			
			Adjustments			
	I	24. 00	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	1	1			1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
6.00	O0600 MAI NTENANCE & REPAI RS O0601 CAFETERI A					6.00
6. 01 6. 02	00601 CAFETERIA					6. 01 6. 02
7. 00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	O1500 PHARMACY					15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	18, 642, 809	ol	18, 642, 809		30.00
	03100 NTENSI VE CARE UNI T	6, 170, 877	1	6, 170, 877		31. 00
40. 00	04000 SUBPROVI DER - I PF	0		C	D	40. 00
41. 00 42. 00	04100 SUBPROVI DER	3, 878, 553		3, 878, 553	3	41. 00 42. 00
43. 00	04300 NURSERY	2, 287, 535		2, 287, 535	5	43. 00
	ANCILLARY SERVICE COST CENTERS			, , , ,		
50.00	05000 OPERATING ROOM	19, 792, 061	1	19, 792, 061		50.00
51. 00 54. 00	O5100 RECOVERY ROOM O5400 RADI OLOGY-DI AGNOSTI C	9, 155, 638	-1	9, 155, 638	1	51. 00 54. 00
57. 00	05700 CT SCAN	1, 434, 915	1	1, 434, 915		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	841, 866	1	841, 866		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 532, 335 10, 909, 128	1	3, 532, 335 10, 909, 128		59. 00 60. 00
60. 00	06001 ONCOLOGY	2, 399, 034	1	2, 399, 034		60.00
60. 02	06002 RADI ATI ON ONCOLOGY	0	o	C		60. 02
65. 00	06500 RESPI RATORY THERAPY	3, 710, 173	1	3, 710, 173		65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	3, 635, 901 2, 364, 213		3, 635, 901 2, 364, 213		66. 00 69. 00
69. 01	06901 CARDI AC REHAB	458, 090		458, 090		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	13, 346, 376		13, 346, 37 <i>6</i>)	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	13, 340, 370	<u> </u>	13, 340, 370)	73.00
90.00	09000 CLI NI C	1, 011, 780	1	1, 011, 780		90.00
91.00	09100 EMERGENCY	10, 219, 054	1	10, 219, 054	1	91.00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C		92. 00 92. 01
	OTHER REIMBURSABLE COST CENTERS		9] /2.0.
95. 00	09500 AMBULANCE SERVICES	2, 532, 853	0	2, 532, 853	3	95. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE					113. 00
118.00	1 1	116, 323, 191	0	116, 323, 191		118. 00
400.00	NONREI MBURSABLE COST CENTERS	105.044	1	105.04	1	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	195, 061	1	195, 061 0		190. 00 192. 00
	19202 VISITOR MEALS	71, 679	1	71, 679		192. 02
	19203 GREAT BEGINNINGS/MATERNAL	199, 948	1	199, 948		192. 03
	19204 LI FELI NE	200 (2)		200 (2)		192. 04
	19205 OWNED PROPERTIES 19211 PARISH NURSING	290, 636 129, 558	1	290, 636 129, 558		192. 05 192. 08
192. 09	19212 BIOTERRORISM GRANT	84, 758		84, 758		192. 09
	19214 BREAST PUMPS	0	-1	700 (0		192. 10
	19209 LUNG CENTER 19210 MGH PHYS PRACT MGMT	729, 634 2, 316, 519	1	729, 634 2, 316, 519		192. 12 192. 14
	19215 MGH MARION SURGEONS	3, 198, 874	1	3, 198, 874		192. 15
	19216 MGH MGH MED ONC	1, 579, 275	1	1, 579, 275		192. 16
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	4, 295, 289 100, 793	1	4, 295, 289 100, 793		192. 17 192. 18
	19218 MGH FALKW MED ASSOC	1, 024, 855	1	1, 024, 855		192. 18
193.00	19300 NONPALD WORKERS	0	0	C	D	193. 00
	19301 MGH FMC NORTHWOOD	1, 326, 486		1, 326, 486		193. 01
	19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS	743, 198 3, 713, 912	1	743, 198 3, 713, 912		193. 02 193. 03
	19304 MGH MAR FAM PRACT	3, 827, 099		3, 827, 099		193. 04
193.05	19305 MGH FMC SWAYZEE	303, 909	o	303, 909	9	193. 05

Provider CCN: 150011

			Т	nte/Time Prepared: 1/23/2016 9:25 am
Cost Center Description	Subtotal	Intern &	Total	7.2072010 7.20 dill
'		Residents Cost		
		& Post		
		Stepdown		
		Adjustments		
	24. 00	25. 00	26. 00	
193.06 19306 MGH PEDIATRIC CTR	1, 711, 699	0	1, 711, 699	193. 06
193. 07 19307 MGH SPECIALTY PHYS	465, 635	0	465, 635	193. 07
193. 08 19308 MGH FMC CONVERSE	416, 977	0	416, 977	193. 08
193.09 19309 MGH UPLAND HEALTH	1, 956, 010	0	1, 956, 010	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	2, 915, 169	0	2, 915, 169	193. 12
193. 15 19315 MGH RIVER VIEW BLDG	0	0	0	193. 15
194. 00 07963 OTHER NONREI MBURSABLE	0	0	0	194. 00
194. 01 07950 MOW	135, 003	0	135, 003	194. 01
194. 02 07951 MENTAL HEALTH	128, 278	0	128, 278	194. 02
194. 03 07952 ADVERTI SI NG	510, 933	0	510, 933	194. 03
194. 04 07953 MGH WORK SOLUTIONS	1, 100, 198	0	1, 100, 198	194. 04
194. 05 07954 MGH TAYLOR UNI VERSITY	210, 297	0	210, 297	194. 05
194.08 07957 MGH SMMP BLDG	349, 890	0	349, 890	194. 08
194.09 07958 MGH AMBUCARE BLDG	64, 529	0	64, 529	194. 09
194.10 07959 MGH 106 LYONS BLDG	5, 685	0	5, 685	194. 10
194. 11 07960 FAI RMOUNT	18, 007	0	18, 007	194. 11
194. 12 07961 GAS CITY	68, 907	0	68, 907	194. 12
194. 13 07962 LYONS	19, 381	0	19, 381	194. 13
194. 14 07964 WABASH	598	0	598	194. 14
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)	150, 531, 870	0	150, 531, 870	202. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of	Form CMS-2552-10
COST ALLOCATION STATISTICS	Provi der CCN: 150011	Period: Work From 07/01/2015	ksheet Non-CMS W
		To 06/30/2016 Date	/Time Prenared

			11/23/2016 9:	25 am
	Cost Center Description	Statistics	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	NURSI NG ADMI NI STRATI ON	13		13.00
14.00	CENTRAL SERVICES & SUPPLY	14		14.00
15.00	PHARMACY	15		15. 00

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

					06/30/2016	Date/lime Pre 11/23/2016 9:	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1.00	2A	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS			T		T	1 4 00
1. 00 4. 00 5. 00 6. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	0 0	434, 169 1, 888, 255 0	1, 888, 255	78, 632 0 C	1, 966, 887 0	1. 00 4. 00 5. 00 6. 00
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A	0	150, 926 0		C	24, 776 0	6. 02
7. 00 8. 00	OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE	0	2, 940, 088 65, 894	65, 894	1 C	8, 280	7. 00 8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	102, 300 208, 590	208, 590	C	41, 536 11, 431	9. 00 10. 00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	21, 819 74, 310	74, 310	1, 527	10, 586	1
15. 00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	95, 225	95, 225	23, 016	106, 735	15. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	1, 346, 612 312, 013				30. 00 31. 00
40. 00 41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF	0 0	0 298, 766	1	7	0 38, 124	40. 00 41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	0) (1	0 28, 479	42. 00 43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1, 077, 863	1, 077, 863	3 C	217, 537	50. 00
51. 00 54. 00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 0	0 644, 785	1	0 5 22, 882	0 100, 684	51. 00 54. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	47, 410 55, 607			1	•
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	157, 097 397, 170			•	59. 00 60. 00
60. 01 60. 02	O6001 ONCOLOGY O6002 RADI ATI ON ONCOLOGY	0	0) (9, 264 0 C		60. 01 60. 02
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	143, 164 27, 461			•	65. 00 66. 00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	247, 927 40, 428			1	69. 00 69. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	0) () C	1	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0) () C		73. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0 0	88, 274 345, 552			•	90. 00 91. 00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	())	0	92. 00 92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	129, 450	129, 450	10, 193	27, 104	95. 00
112 00	SPECIAL PURPOSE COST CENTERS			I		I	1112 00
118.00	11300 I NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	11, 341, 155	11, 341, 155	376, 643	1, 534, 160	113. 00 118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		41, 986	254	•	190. 00 192. 00
192. 02	19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL	0	1) 0 1, 036	0	192. 02 192. 03
192. 04	19204 LIFELINE 19205 OWNED PROPERTIES	0	0			0	192. 04 192. 05
192. 08	19211 PARISH NURSING 19212 BIOTERRORISM GRANT	0	10, 660	10, 660	377	1, 351	192. 08 192. 09
192. 10	19214 BREAST PUMPS 19209 LUNG CENTER	0	0		984	0	192. 10 192. 12
192. 14	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	0	0		8, 995 4, 492	29, 142	192. 14 192. 15
192. 16	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	0	0		7, 576	20, 635	192. 16
192. 18	19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION	0	0		53	1, 317	192. 18 192. 19
193.00	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD	0 0	0		2, 709	0	193. 00
193. 02	19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS	0	1	1	1, 484	9, 509	193. 02 193. 03
	19304 MGH MAR FAM PRACT	0	0) (7, 275		

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011

				0 06/30/2016	11/23/2016 9:	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
	0	1. 00	2A	4. 00	5. 00	
193.05 19305 MGH FMC SWAYZEE	0	0	C	711	3, 937	193. 05
193.06 19306 MGH PEDIATRIC CTR	0	0	C	2, 620	22, 021	193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	0	C	752	6, 008	193. 07
193.08 19308 MGH FMC CONVERSE	0	0	(1, 054	5, 415	193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	(3, 549		
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	(4, 202		
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	C	0		194. 02
194. 03 07952 ADVERTI SI NG	0	0	C	2, 167		194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	0	C	3, 519		
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0	C	502		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
194. 11 07960 FAI RMOUNT	0	0	(0		194. 11
194. 12 07961 GAS CITY	0	0	(0		194. 12
194. 13 07962 LYONS	0	0	(0		194. 13
194. 14 07964 WABASH	0	U			8	194. 14
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		11 202 001	11 202 001	424 140		201.00
202.00 TOTAL (sum lines 118-201)	0	11, 393, 801	11, 393, 801	434, 169	1, 966, 887	J202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

				1'	00/30/2010	11/23/2016 9:	
	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	475 700				6. 00
6. 01	00601 CAFETERI A 00602 CAFETERI A	0	175, 702	1/0 0/0			6. 01
6. 02 7. 00	00700 OPERATION OF PLANT	0	169, 060	169, 060 4, 087	3, 081, 914		6. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	4, 007	33, 958	108, 132	8. 00
9. 00	00900 HOUSEKEEPING	0	Ö	0	52, 719	1, 189	9. 00
10.00	01000 DI ETARY	0	0	0	107, 495	1, 787	10. 00
13.00	01300 NURSING ADMINISTRATION	0	0	2, 519	11, 244	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	1, 199	38, 295	1, 218	14. 00
15. 00	01500 PHARMACY	0	0	7, 310	49, 073	0	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	ol	30, 460	693, 961	25, 784	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	10, 198	160, 792	6, 638	31. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	10, 170	0	0, 030	40.00
41. 00	04100 SUBPROVI DER - I RF	0	o	4, 609	153, 966	3, 535	41. 00
42.00	04200 SUBPROVI DER	0	0	0	O	0	42. 00
43.00	04300 NURSERY	0	0	4, 017	0	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		ol	21 011	FFF 4/F	15.075	F0 00
50. 00 51. 00	05000 OPERATING ROOM	0	0	21, 011 0	555, 465 0	15, 075 0	50. 00 51. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	11, 547	332, 283	9, 665	54. 00
57. 00	05700 CT SCAN	o o	o	2, 139	24, 432	2, 495	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 117	28, 657	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	2, 499	80, 958	2, 861	59. 00
60.00	06000 LABORATORY	0	0	11, 732	204, 677	0	60. 00
60. 01	06001 ONCOLOGY	0	0	0	0	0	60. 01
60. 02 65. 00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	0	0	5, 154	73, 778	396	60. 02 65. 00
66. 00	06600 PHYSI CAL THERAPY		0	3, 512	14, 152	3, 599	66.00
69. 00	06900 ELECTROCARDI OLOGY	o o	o	3, 973	127, 767	698	69. 00
69. 01	06901 CARDI AC REHAB	0	0	595	20, 834	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	ol	1, 121	45, 491	340	90. 00
91. 00	09100 EMERGENCY	o o	0	18, 245	178, 076	27, 224	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
05 00	OTHER REIMBURSABLE COST CENTERS		ما	/ 21/	(710	F (00	05 00
95. 00	09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0	6, 316	66, 710	5, 609	95. 00
113. 00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	169, 060	153, 360	3, 054, 783	108, 113	118. 00
	NONREI MBURSABLE COST CENTERS	T					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	103	21, 637		190. 00 192. 00
	19202 VISITOR MEALS	0	6, 642	0	o		192. 02
	19203 GREAT BEGINNINGS/MATERNAL	0	0	0	Ö		192. 03
	19204 LI FELI NE	0	0	0	0	0	192. 04
	19205 OWNED PROPERTIES	0	0	0	0		192. 05
	19211 PARI SH NURSI NG	0	0	215	5, 494		192. 08
	19212 BIOTERRORISM GRANT 19214 BREAST PUMPS	0	0	0	0		192. 09 192. 10
	19209 LUNG CENTER	0	0	826	0		192. 10
	19210 MGH PHYS PRACT MGMT	o o	0	5, 860	o		192. 14
	19215 MGH MARION SURGEONS	0	0	3, 255	o		192. 15
	19216 MGH MGH MED ONC	0	0	0	0	0	192. 16
	19217 MGH FMC SOUTH	0	0	0	0		192. 17
	19218 MGH FAI RM MED ASSOC	0	0	1 775	0		192. 18
	19219 MGH FMC MARION 19300 NONPAID WORKERS		0	1, 775	0		192. 19 193. 00
	19301 MGH FMC NORTHWOOD		0	0	ol Ol		193. 00
	19302 MGH FMC GAS CITY		ol	0	ő		193. 02
193. 03	19303 MGH HOSPITALISTS	0	О	0	o	0	193. 03
	19304 MGH MAR FAM PRACT	0	0	0	0		193. 04
	19305 MGH FMC SWAYZEE	0	0	0	0		193. 05
	19306 MGH PEDIATRIC CTR 19307 MGH SPECIALTY PHYS		0	2, 204 536	0		193. 06 193. 07
	19308 MGH FMC CONVERSE		0	0	0		193. 07
	1 - 1	<u>, </u>	<u> </u>		<u> </u>		

Provider CCN: 150011

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: | 11/23/2016 9: 25 am

					11/23/2016 9:	25 am
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	
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	0	193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0	0	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	926	0	0	194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	0	0	0	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	0	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194. 10
194. 11 07960 FAI RMOUNT	0	0	0	0	0	194. 11
194. 12 07961 GAS CITY	0	0	0	0	0	194. 12
194. 13 07962 LYONS	0	0	0	0	0	194. 13
194. 14 07964 WABASH	0	0	0	0	0	194. 14
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	175, 702	169, 060	3, 081, 914	108, 132	202. 00

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011

			To	06/30/2016	Date/Time Pre	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	25 diii
	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	197, 744 2, 697 843	332, 000 0	67, 895			1. 00 4. 00 5. 00 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00 10. 00 13. 00
	1	ŭ	1		284 056	14. 00 15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	2,077	0	J O	<u> </u>	204, 030] 13.00
03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY	39, 112 10, 789 0 9, 440 0	188, 863 40, 227 0 32, 043 0 0	6, 143 0 2, 776 0	33, 499 13, 135 0 2, 627 0 0	0 0 0 0 0	31. 00 40. 00 41. 00 42. 00
	27 447	0	12 454	22 524	0	E0 00
05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 8, 429 506 0		0 0 0	0 2, 627 0 0	0 0 0	51. 00 54. 00 57. 00 58. 00
05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 ONCOLOGY 06002 RADIATION ONCOLOGY 06500 RESPIRATORY THERAPY	3, 372 9, 440 0 0 7, 080	0 0 0 0	0 0	3, 940 7, 881 328 0 7, 224	0 0 0 0	59. 00 60. 00 60. 01 60. 02 65. 00
06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0 4, 552 5, 057 0 0	0 0 0 0	2, 393 359 0	0 1, 970 0 0 0	0 0 0 0 0 284 056	66. 00 69. 00 69. 01 71. 00 72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS			<u> </u>	~1		
09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	3, 372 37, 762 0	-	10, 990	0 14, 448 0	0	91. 00 92. 00
	1. 180	0	3, 804	1, 313	0	95. 00
SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	178, 189			111, 518		113. 00
19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES 19211 PARISH NURSING 19212 BIOTERRORISM GRANT 19214 BREAST PUMPS 19209 LUNG CENTER 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 19305 MGH FMC SWAYZEE 19306 MGH PEDIATRIC CTR	0 0 0 10, 789 337 0 0 0 1, 349 0 6, 743 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 323 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 3, 743 0 2, 627 0 2, 627 0 328 1, 970 0 3, 940 328 328 328	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. 04 192. 05 192. 08 192. 09 192. 10 192. 12 192. 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
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00601 CAFETERIA 00602 CAFETERIA 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IRF 04200 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 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 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 DRUGS CHARGED TO PATIENTS 07500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 11300 INTEREST E	SENERAL SERVICE COST CENTERS	GENERAL SERVICE COST CENTERS	COST CENTER DESCRIPTION	COST Center Description	COST CONTINUE DESCRIPTION

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Provi der CCN: 150011

			10	06/30/2016	Date/IIme Prep	
Coot Conton Decemintion	HOUSEKEEDING	DICTARY	MUDCLNC	CENTRAL	11/23/2016 9: 2	25 am
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG		PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	0.00	10.00	12.00	SUPPLY	15 00	
400 00 40000 NOLL ENG. 00NU/EDGE	9. 00	10.00	13. 00	14.00	15. 00	100.00
193. 08 19308 MGH FMC CONVERSE	0	0	0	328		193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	0	2, 955		193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0		193. 10
193. 11 19311 MGH MGH PSYCHLATRY	0	0	0	0	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	o	34, 820	0	o	0	194. 01
194. 02 07951 MENTAL HEALTH	0	33, 085	0	o	0	194. 02
194. 03 07952 ADVERTI SI NG	o	0	0	ol	0	194. 03
194. 04 07953 MGH WORK SOLUTIONS	0	0	0	657	0	194. 04
194. 05 07954 MGH TAYLOR UNI VERSITY	0	0	0	ol	0	194. 05
194.08 07957 MGH SMMP BLDG	o	0	0	ol	0	194. 08
194. 09 07958 MGH AMBUCARE BLDG	0	0	0	ol	0	194. 09
194. 10 07959 MGH 106 LYONS BLDG	0	0	0	ol	0	194. 10
194. 11 07960 FAI RMOUNT	o	0	0	ol	0	194. 11
194. 12 07961 GAS CITY	0	0	0	ol	0	194. 12
194. 13 07962 LYONS	o	0	o	ol	0	194. 13
194. 14 07964 WABASH	0	0	0	o		194. 14
200.00 Cross Foot Adjustments		-				200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	197, 744	332, 000	67, 895	131, 349		
202.00 101/1E (30m 11103 110 201)	1 , , , , , , , ,	332, 000	0,,075	101, 547	201,000	_52.00

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MARION GENERAL HOSPITAL Provi der CCN: 150011

Cost Center Description					Т	o 06/30/2016 Date/Time Pr 11/23/2016 9	
## REPAIL SERVICE COST CENTERS 24.00 20 00 00 00 00 00 00		Cost Center Description	Subtotal		Total	11/23/2010 7	23 4111
Strephone							
100							
			24 00		26.00	_	
4. 00 0.0000 DATE TABLE SERVER IS DEPARTMENT		GENERAL SERVICE COST CENTERS	24.00	25.00	20.00		
5.00							
0.00 00000 MAINTENANCE & REPAIRS 6.01 0.001 CAFETERIA 6.01 0.001 CAFETERIA 6.01 0.001 CAFETERIA 6.02 0.0000 MAINTENANCE & REPAIRS 6.02 0.0000 MAINTENANCE & REPAIRS 6.02 0.0000 MAINTENANCE SERVICE 9.00 0.0000 MAINTENANCE 9.0000 MAINTENANCE 9.00 0.0000 MAINTENANCE 9.0000 MAINT		1 1					
0.00 0.000 CALTERIAN							
2.00 0.0700 0.0700 0.0FEATION OF PLANT							
0.000 0.00							
10.00 1000 DETAIN		1					
13.00 13.00 MIRSING ADMINISTRATION		1					
14.00 1400							
IMPART ENT ROUTINE SERVICE COST CENTERS 2, 619, 284 0 2, 619, 284 30, 00 31, 00 31000 JULIS & PERIO LATRICS 2, 619, 284 0 2, 619, 284 31, 00 41, 00 4000 31000 JULIS & PERIO LATRICS 197, 284 0 4, 47 31, 00 41, 00 42, 00 420, 00							
30.00	15. 00						15. 00
31.00 03100 INTENSI VE CARE UNIT 646, 487 0 646, 487 0 0 40, 00 41.00 04000 SUBPROVIDER - IPF 50 0 0 0 0 0 41.00 04000 SUBPROVIDER 1FF 555, 317 0 0 555, 317 41, 00 43.00 04300 SUBPROVIDER 1FF 555, 317 0 0 0 42, 00 43.00 04300 SUBPROVIDER 1 141, 00 0 0 44, 107 43.00 04300 SUBPROVIDER 1 141, 00 0 0 44, 107 43.00 04300 SUBPROVIDER 1 141, 00 0 0 1, 949, 780 51.00 0500 DEPART IN REGISTRY 1 1, 129, 700 0 1, 1949, 780 51.00 05100 RECOVERY ROUN 1, 947, 780 0 0 1, 1949, 780 0 51, 00 53.00 0500 RECOVERY ROUN 1, 132, 900 0 1, 132, 900 55, 00 55.00 0500 CT SCAN 9 1, 144 0 94, 164 55, 00 55.00 0500 CT SCAN 9 1, 144 0 94, 164 55, 00 55.00 0500 CT SCAN 9 1, 144 9 9 1, 144 9 9 55.00 0500 CT SCAN 9 1, 144 9 9 9 1, 144 9 9 1, 144 9 9 1, 144 9 9 1, 144 9 9 1, 144 9 9 1, 144 9 9 1, 144 9 9 1, 144 9 9 1, 144 9 9 1, 144	30.00		2 619 284		2 619 284	П	30.00
1.00 04100 SUBPROVIDER - 1 FF 555, 317 0 055, 317 0 042, 00 042, 00 0420			1 ' '	1			
42.00 04200 UNSERY 44, 107 0		1		-	C		1
44, 107 0 44, 107 0 44, 107 0 44, 107 30 30 30 30 30 30 30			555, 317	-	555, 317		
50.00 05000 0FERDATI ING ROOM 1, 949, 780 0 0, 1, 949, 780 0 51, 00 510 0 570 0 0 0 0 0 0 0 0 0		1	44, 107	- 1	44, 107	,	
151 0.0	50.00				4 040 700		
1.132, 902 9.1, 132, 902 9.1, 132, 902 9.1, 132, 902 9.7, 00 9.70 9.7, 00 9.70 9.7, 104 9.8, 104 9.7, 104 9.8, 104 9.7, 104 9.8, 104 9.7, 104 9.8, 104 9.7, 104 9.7, 104 9.8, 104 9.7, 104 9.			1, 949, 780	- 1			
58. 00 05800 MARNITIC RESONANCE I MAGI NG (MRI) 97, 144 0 97, 144 0 97, 172 59, 00 0590 0590 0600 CARDIA CA CATHEER IZATI ON 297, 721 0 297, 721 59, 00 00 0 0 0 0 0 0 0			1, 132, 902	- 1	_		
59.00 05900 CARDIA C CATHETER ZATI ON 297, 721 0 297, 721 59.00		l	1	1			
60.00 0.0000 0.0000ATORY 782, 0.35 0 782, 0.35 0.0 0			1	1			
0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000000		l	1	_			
65. 00 0.5			1	0			
66. 00 06600 PHYSI CAL THERAPY 113, 462 0 113, 462 0 069. 00 06900 LECTROCARDIOLOGY 419, 233 069. 00 069. 01 06901		1	202 201	-	202 201		
69. 00 06900 0610 0610 0610 0710		1	1	-			
171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	69. 00	06900 ELECTROCARDI OLOGY	1	1			69. 00
172.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 347,964 0 347,964 72.00		l	1	-			
73.00			-		C		
90. 00		07300 DRUGS CHARGED TO PATIENTS	347, 964	0	347, 964		73. 00
91.00 09100 DERRECENCY 780, 099 0 780, 099 92.00 09200	90 00		152 089		152 080	, 	90.00
92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 01 09201 085ERVATION BEDS (DISTINCT PART) 0 0 0 0 92. 01 071HER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 251, 679 0 251, 679 95. 00 085EVELAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 10, 693, 796 0 10, 693, 796 118. 00 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 65, 845 0 65, 845 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192. 00 192. 01 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192. 00 192. 02 19202 VISITOR MEALS 6, 642 0 6, 642 192. 02 192. 03 19203 GREAT BEGI INNINOS/MATERNAL 3, 859 0 3, 859 192. 03 192. 04 192. 05 19205 OMNED PROPERTIES 12, 191 0 12, 191 192. 05 192. 09 19212 BI OTERRORI SM GRANT 1, 404 0 1, 404 192. 05 192. 10 19214 BREAST PUMPS 0 0 0 192. 10 192. 11 19210 MGH PHYS PRACT MGMT 45, 346 0 45, 346 192. 14 192. 15 19216 MGH MGH MGH DONC 20, 639 0 20, 639 192. 16 192. 17 19217 MGH FMC SOUTH 71, 320 0 71, 320 192. 16 192. 17 19218 MGH FMC SOUTH 71, 320 0 71, 320 192. 16 193. 01 19301 MGH FMC MARION 19, 465 0 19, 465 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 0 0 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 19, 465 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 19, 465 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 19, 465 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 0 0 0 0 193. 01 19301 MGH FMC MARION 19, 465 0 19, 465 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 19, 465 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 0 0, 6, 817 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 0 0, 6, 817 193. 01 193. 01 19301 MGH FMC MARION 19, 465 0 0 0,							
OTHER REI MBURSABLE COST CENTERS Q95.00 ABULANCE SERVI CES Q51, 679 Q 251, 679 Q		1 1		0			
95. 00 09500 AMBULANCE SERVI CES 251, 679 0 251, 679 95. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 1 NTEREST EXPENSE 113. 00 190. 00	92. 01		0	0	C	0	92. 01
113.00	95. 00		251, 679	0	251, 679		95. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) 10, 693, 796 10, 693	112 00		I			I	112 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 65,845 0 65,845 0 192.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 19			10, 693, 796	О	10, 693, 796		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 02 19202 VI SI TOR MEALS 6, 642 0 6, 642 192. 02 19202 VI SI TOR MEALS 6, 642 0 6, 642 192. 02 19202 VI SI TOR MEALS 6, 642 0 6, 642 192. 02 19202 VI SI TOR MEALS 6, 642 0 6, 642 192. 02 19202 VI SI TOR MEALS 6, 642 0 6, 642 192. 02 19202 VI SI TOR MEALS 7 0 0 0 0 192. 03 192. 04 19204 LI FELI NE 0 0 0 0 0 192. 04 192. 04 19204 LI FELI NE 0 0 0 0 0 192. 04 192. 04 19205 19205 0WNED PROPERTI ES 12, 191 0 12, 191 192. 05 192. 08 19211 PARI SH NURSI NG 18, 434 0 18, 434 192. 08 192. 19 19212 BI OTERRORI SM GRANT 1, 404 0 1, 404 192. 09 19212 BI DEFERORI SM GRANT 1, 404 0 1, 404 192. 09 192. 10 19214 BREAST PUMPS 0 0 0 0 192. 10 192. 14 19209 LUNG CENTER 11, 227 0 11, 227 192. 14 19210 MGH PHYS PRACT MGMT 45, 346 0 45, 346 192. 15 19215 MGH MARI ON SURGEONS 52, 444 0 52, 444 192. 16 192. 16 19216 MGH MGH MED ONC 20, 639 0 20, 639 192. 16 192. 16 19216 MGH MGH MED ONC 20, 639 0 20, 639 192. 16 192. 17 192. 17 192. 17 192. 17 MGH FMC SOUTH 71, 320 0 71, 320 192. 17 192. 18 19218 MGH FAIR MED ASSOC 1, 370 0 1, 370 192. 18 19218 MGH FAIR MED ASSOC 1, 370 0 1, 370 192. 18 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 MGH FMC MARI ON 192. 1949. 249 193. 01 193. 04 19304 MGH MAR FAM PRACT 60, 817 0 60, 817	400.00				(5.045		
192. 02 19202 VI SI TOR MEALS 192. 03 19203 GREAT BEGINNI NGS/MATERNAL 3, 859 0 3, 859 192. 04 19204 LI FELI NE 0 0 0 0 192. 05 19205 OWNED PROPERTIES 192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 1, 404 192. 09 19212 BI OTERRORI SM GRANT 1, 404 192. 10 19214 BREAST PUMPS 0 0 0 0 192. 10 19214 IP 19209 LUNG CENTER 11, 227 192. 14 19210 MGH PHYS PRACT MGMT 45, 346 0 45, 346 192. 14 19210 MGH MARI ON SURGEONS 52, 444 192. 15 19215 MGH MGH MED ONC 20, 639 192. 17 19217 MGH FAI RM MED ASSOC 1, 370 1, 320 192. 19 19219 MGH FMC MARI ON 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 193. 01 193. 01 193. 01 193. 04		1	1	1			
192. 04 192. 04 192. 05 192.05 192.05 192.08 192.11 192.10 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.09 192.12 192.10 192.12 192.10 192.12 192.10 192.12 192.10 192.12 192.11 192.10 192.12 192.12 192.11 192.12 192.12 192.12 192.12 192.13 192.15 192.15 192.15 192.15 192.16 192.16 192.16 192.16 192.16 192.16 192.16 192.18 192.18 192.18 192.18 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 193.00 193.01 193.01 193.01 193.01 193.04 193.04 193.04 193.04 193.04		1 1	1	_	_		
192. 05		1 1	1	1			
192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 192. 09 19214 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS 0 0 0 0 192. 10 192. 12 19209 LUNG CENTER 11, 227 0 11, 227 192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARI ON SURGEONS 192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC 192. 18 19218 MGH FAI RM MED ASSOC 193. 00 19300 NONNPAI D WORKERS 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 193. 04 19304 MGH MGR FAM PRACT 193. 04		1 1	-	_	_		
192. 10 192.14 BREAST PUMPS 0 0 0 192.17 192.19 19209 LUNG CENTER 11, 227 0 11, 227 192.14 19210 MGH PHYS PRACT MGMT 45, 346 192. 15 19215 MGH MRI ON SURGEONS 192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC 192. 19 19219 MGH FMC MARI ON 192. 19 19219 MGH FMC MARI ON 192. 19 19219 MGH FMC MARI ON 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 19300 MGH FMC MARI ON 193. 01 19300 MGH FMC GAS CITY 193. 02 19302 MGH FMC GAS CITY 193. 04 19304 MGH MAR FAM PRACT 0 0 0 0 193. 04 193. 04 193. 04 193. 04 193. 04 193. 04 193. 04			1	_			
192. 12 192.09 LUNG CENTER 11, 227 192.14 19210 MGH PHYS PRACT MGMT 45, 346 0 45, 346 192. 14 192. 15 192. 15 192. 15 192. 16 192. 16 192. 16 192. 17 192. 17 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 19			1				
192. 14 19210 MGH PHYS PRACT MGMT 45, 346 0 45, 346 192. 14 192. 15 19215 MGH MARI ON SURGEONS 52, 444 0 52, 444 192. 15 192. 16 192. 16 192. 16 192. 17 192. 17 MGH FMC SOUTH 71, 320 0 71, 320 192. 17 192. 18 192. 18 192. 18 192. 18 192. 19 MGH FMC MARI ON 19, 465 0 19, 465 192. 19 193. 00 193. 00 NONPALD WORKERS 0 0 0 193. 00 193. 01 193. 01 MGH FMC NORTHWOOD 20, 335 0 20, 335 193. 03 193. 03 193. 03 193. 03 193. 04 1			-	-	_		
192. 16 192.16 MGH MGH MGH MED ONC 20, 639 0 20, 639 192. 16 192. 17 192.17 MGH FMC SOUTH 71, 320 0 71, 320 192. 17 192. 18 192.18 MGH FAI RM MED ASSOC 1, 370 0 1, 370 192. 18 192. 19 19219 MGH FMC MARI ON 19, 465 0 19, 465 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 20, 335 0 20, 335 193. 02 19302 MGH FMC GAS CI TY 12, 963 0 12, 963 193. 03 19303 MGH HOSPI TALI STS 49, 249 0 49, 249 193. 03 193. 04 19304 MGH MAR FAM PRACT 60, 817 0 60, 817 193. 04		1					
192. 17 19217 MGH FMC SOUTH 71, 320 0 71, 320 192. 17 192. 18 19218 MGH FAI RM MED ASSOC 1, 370 0 1, 370 192. 18 192. 19 19219 MGH FMC MARI ON 19, 465 0 19, 465 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 20, 335 0 20, 335 193. 02 19302 MGH FMC GAS CITY 12, 963 0 12, 963 193. 03 19303 MGH HOSPITALISTS 49, 249 0 49, 249 193. 04							
192. 18 192.18 MGH FAI RM MED ASSOC 1,370 0 1,370 192. 18 192. 19 19219 MGH FMC MARI ON 19,465 0 19,465 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 20,335 0 20,335 193. 01 193. 02 19302 MGH FMC GAS CITY 12,963 0 12,963 193. 02 193. 03 19303 MGH HOSPI TALI STS 49,249 0 49,249 193. 03 193. 04 19304 MGH MAR FAM PRACT 60,817 0 60,817 193. 04				1			
192. 19 19219 MGH FMC MARI ON 19, 465 0 19, 465 193. 00 19300 NONPAI D WORKERS 0 0 193. 00 193. 01 19301 MGH FMC NORTHWOOD 20, 335 0 20, 335 193. 01 193. 02 19302 MGH FMC GAS CITY 12, 963 0 12, 963 193. 02 193. 03 19303 MGH HOSPITALISTS 49, 249 0 49, 249 193. 03 193. 04 19304 MGH MAR FAM PRACT 60, 817 0 60, 817 193. 04				1			
193. 01 19301 MGH FMC NORTHWOOD 20, 335 0 20, 335 193. 01 193. 02 19302 MGH FMC GAS CLTY 12, 963 0 12, 963 193. 02 193. 03 19303 MGH HOSPITALISTS 49, 249 0 49, 249 193. 03 193. 04 19304 MGH MAR FAM PRACT 60, 817 0 60, 817 193. 04	192. 19	19219 MGH FMC MARION	19, 465	0	19, 465	5	192. 19
193. 02 19302 MGH FMC GAS CLTY			-	-	_		
193. 03 19303 MGH HOSPI TALI STS			1	1			
	193. 03	19303 MGH HOSPI TALI STS	49, 249	O	49, 249)	193. 03
170. 00 17000 mon 1 mo Smrt2EE 4, 770 0 4, 770 193. 03							
	- 73.00	1.7555 mort rimo Smittee	1 4, 770	<u>, </u>	4, 770	<u>'I</u>	11 70. 00

| Peri od: | Worksheet B | From 07/01/2015 | Part II | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150011

			T	o 06/30/2016	Date/Time Prepared: 11/23/2016 9:25 am
Cost Center Description	Subtotal	Intern &	Total		1172372010 7.23 dill
, , , , , , , , , , , , , , , , , , ,		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
193.06 19306 MGH PEDIATRIC CTR	27, 173	0	27, 173		193. 06
193. 07 19307 MGH SPECIALTY PHYS	7, 296	0	7, 296		193. 07
193. 08 19308 MGH FMC CONVERSE	6, 797	0	6, 797		193. 08
193.09 19309 MGH UPLAND HEALTH	31, 759	0	31, 759		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	42, 292	0	42, 292		193. 12
193. 15 19315 MGH RIVER VIEW BLDG	0	0	0		193. 15
194.00 07963 OTHER NONREI MBURSABLE	0	0	0		194. 00
194. 01 07950 MOW	34, 820	0	34, 820		194. 01
194. 02 07951 MENTAL HEALTH	33, 085	0	33, 085		194. 02
194. 03 07952 ADVERTI SI NG	9, 638	0	9, 638		194. 03
194. 04 07953 MGH WORK SOLUTIONS	18, 484	0	18, 484		194. 04
194. 05 07954 MGH TAYLOR UNI VERSI TY	3, 250	0	3, 250		194. 05
194.08 07957 MGH SMMP BLDG	4, 572	0	4, 572		194. 08
194.09 07958 MGH AMBUCARE BLDG	843	0	843		194. 09
194.10 07959 MGH 106 LYONS BLDG	74	0	74		194. 10
194. 11 07960 FAI RMOUNT	235	0	235		194. 11
194. 12 07961 GAS CITY	900	0	900		194. 12
194. 13 07962 LYONS	253	0	253		194. 13
194. 14 07964 WABASH	8	0	8		194. 14
200.00 Cross Foot Adjustments	0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	11, 393, 801	0	11, 393, 801		202. 00

	Financial Systems	MARION GENERA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2015 o 06/30/2016		pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		1.00	4. 00	5A	5. 00	6. 00	
	GENERAL SERVICE COST CENTERS				l		
1. 00 4. 00 5. 00 6. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	365, 536 13, 929 60, 579	44, 686, 220 8, 093, 528	1		291, 028	1. 00 4. 00 5. 00 6. 00
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A	4, 842 0	0	0 0	1, 570, 401 0	4, 842 0	6. 01 6. 02
7.00	00700 OPERATION OF PLANT	94, 324	580, 291	0	8, 372, 987	94, 324	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 114	0	0	524, 809		
9.00	00900 HOUSEKEEPI NG	3, 282	0	0	2, 632, 694		
10. 00 13. 00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON	6, 692 700	000 405	5 0	724, 565		
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 384	908, 685 157, 130	1	.,,	l e	
15. 00	01500 PHARMACY	3, 055	2, 368, 844	1			
	INPATIENT ROUTINE SERVICE COST CENTERS	2, 223		-	27 . 227 . 2	2, 222	
30.00	03000 ADULTS & PEDIATRICS	43, 202	6, 548, 941	0			30.00
31. 00	03100 INTENSIVE CARE UNIT	10, 010	2, 346, 724	· O	4, 040, 767	10, 010	1
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	9, 585	970, 710			l	1
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY		945, 953	0 0		0	
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	745, 755	<u>, </u>	1,005,104	0	43.00
50.00	05000 OPERATI NG ROOM	34, 580	C	0	13, 786, 713	34, 580	50.00
51.00	05100 RECOVERY ROOM	O	0	o	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 686	2, 355, 116	1	-,,	20, 686	1
57.00	05700 CT SCAN	1, 521	424, 497	1	1, 081, 205		
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 784	221, 675		609, 031	1, 784	
60.00	06000 LABORATORY	5, 040 12, 742	525, 640 2, 260, 597	1	2, 559, 524 8, 187, 280		
60. 01	06001 ONCOLOGY	12, 742	953, 435	1	1, 984, 688		1
60. 02	06002 RADIATION ONCOLOGY	Ö	0	o o		Ō	1
65.00	06500 RESPI RATORY THERAPY	4, 593	1, 231, 891	0	2, 601, 567	4, 593	65. 00
66.00	06600 PHYSI CAL THERAPY	881	1, 778, 724		_, _, _, _,	l e	
69. 00	06900 ELECTROCARDI OLOGY	7, 954	744, 364	1	1, 440, 124		
69. 01 71. 00	O6901 CARDI AC REHAB O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 297	122, 960		238, 098	1, 297 0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		_	0	1
	07300 DRUGS CHARGED TO PATIENTS	o	0	o o		Ö	1
	OUTPATIENT SERVICE COST CENTERS	'		1			
	09000 CLI NI C	2, 832	280, 644				90. 00
	09100 EMERGENCY	11, 086	3, 896, 201	0	6, 781, 098	11, 086	91.00
92. 00 92. 01	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O9201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 00 92. 01
72.01	OTHER REIMBURSABLE COST CENTERS	<u> </u>		η <u></u>	0	0	72.01
95.00	09500 AMBULANCE SERVICES	4, 153	1, 049, 119	0	1, 717, 952	4, 153	95. 00
	SPECIAL PURPOSE COST CENTERS	,					
	11300 I NTEREST EXPENSE	242.047	00 7/5 //0	05 0/5 0/0	07 000 040	200 200	113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	363, 847	38, 765, 669	-25, 865, 262	97, 238, 840	289, 339	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 347	26, 176	0	96, 835	1 347	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	20, . , 0	o o			192. 00
	19202 VISITOR MEALS	0	0	0	0	0	192. 02
	19203 GREAT BEGINNINGS/MATERNAL	0	106, 583				192. 03
	19204 LI FELI NE	0	0	0	_		192. 04
	19205 OWNED PROPERTIES 19211 PARISH NURSING	0 342	38, 800		88, 836		192. 05 192. 08
	19211 PART SHI NORSTING 19212 BLOTERRORI SM GRANT	0	30, 566		85, 641 70, 194		192. 08
	19214 BREAST PUMPS		30, 300		0, 174		192. 10
	19209 LUNG CENTER	o	101, 226	0	596, 883		192. 12
	19210 MGH PHYS PRACT MGMT	0	925, 815	0	.,	l	192. 14
	19215 MGH MARI ON SURGEONS	0	462, 295				192. 15
	19216 MGH MGH MED ONC		414 770 720	•	.,,		192. 16
	19217 MGH FMC SOUTH 19218 MGH FALRM MED ASSOC		779, 720 5, 416	1	3, 445, 179 83, 474	l e	192. 17 192. 18
	19219 MGH FMC MARION		225, 516	1		l .	192. 19
193.00	19300 NONPALD WORKERS		0	1			193. 00
193. 01	19301 MGH FMC NORTHWOOD	0	278, 780	1	.,		193. 01
	19302 MGH FMC GAS CITY	0	152, 745	1	,		193. 02
193. 03	19303 MGH HOSPI TALI STS	0	74, 369	9 0	3, 075, 767	<u> </u>	193. 03

| Peri od: | Worksheet B-1 | From 07/01/2015 | To 06/30/2016 | Date/Time Prepared: Provider CCN: 150011

			T ₁	06/30/2016	Date/Time Pro 11/23/2016 9:	epared:
	CAPI TAL				11/23/2010 9.	25 alli
	RELATED COSTS					
Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	MAINTENANCE &	
	FLXT	BENEFITS		& GENERAL	REPAI RS	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
	FEET)	(GROSS		COST)	FEET)	
	,	SALARI ES)		ŕ	ĺ	
	1.00	4.00	5A	5. 00	6. 00	
193.04 19304 MGH MAR FAM PRACT	0	748, 746	0	3, 143, 933		193. 04
193.05 19305 MGH FMC SWAYZEE	0	73, 226	0	249, 559	C	193. 05
193.06 19306 MGH PEDIATRIC CTR	0	269, 618	0	1, 395, 755	C	193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	77, 416	0	380, 834	C	193. 07
193.08 19308 MGH FMC CONVERSE	0	108, 440	0	343, 199	C	193. 08
193.09 19309 MGH UPLAND HEALTH	0	365, 258	0	1, 600, 738		193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	C	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0	0	0	C	193. 11
193. 12 19312 OB/GYN	0	432, 487	0	2, 414, 269		193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	C	193. 15
194. 00 07963 OTHER NONREI MBURSABLE	0	0	0	0		194. 00
194. 01 07950 MOW	0	0	0	0	C	194. 01
194. 02 07951 MENTAL HEALTH	0	0	0	0	C	194. 02
194. 03 07952 ADVERTI SI NG	0	223, 044	0	414, 869		194. 03
194.04 07953 MGH WORK SOLUTIONS	0	362, 216	0	906, 893		194. 04
194.05 07954 MGH TAYLOR UNIVERSITY	0	51, 679	0	174, 163		194. 05
194.08 07957 MGH SMMP BLDG	0	0	0	289, 770		194. 08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	53, 441		194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	4, 708		194. 10
194. 11 07960 FAI RMOUNT	0	0	0	14, 913		194. 11
194. 12 07961 GAS CLTY	0	0	0	57, 067		194. 12
194. 13 07962 LYONS	0	0	0	16, 051		194. 13
194. 14 07964 WABASH	0	0	0	495	(194. 14
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	11, 393, 801	20, 046, 275		25, 865, 262	(202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	31. 170120	0. 448601		0. 207475		
204.00 Cost to be allocated (per Wkst. B,		434, 169	1	1, 966, 887	(204. 00
Part II)						l
205.00 Unit cost multiplier (Wkst. B, Part		0. 009716		0. 015777	0. 000000	205. 00
)					l	1

	FINANCIAI SYSTEMS	MARTUN GENERA		CCN 150011 D		Waster at D 1	
COSTA	LLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 07/01/2015 o 06/30/2016	Worksheet B-1 Date/Time Pre 11/23/2016 9:	pared:
	Cost Center Description	CAFETERIA (MEALS SERVED)	CAFETERI A (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	20 diii
		6. 01	6. 02	7.00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS			I			1 00
1. 00 4. 00 5. 00 6. 00 6. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00601 CAFETERIA	266, 158					1. 00 4. 00 5. 00 6. 00 6. 01
6. 02	00602 CAFETERI A	256, 097	1, 361, 119				6. 02
7.00	00700 OPERATION OF PLANT	0	32, 905	1			7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	0	0	2, 114		40.004	8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY		0	3, 282 6, 692		60, 996 832	
13. 00	01300 NURSING ADMINISTRATION	0	20, 282			260	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	9, 650			1, 300	
15. 00	01500 PHARMACY	0	58, 856	3, 055	0	832	15. 00
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	245, 223	43, 202	196, 605	12, 064	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	82, 106			3, 328	1
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	
41. 00 42. 00	04100 SUBPROVI DER – I RF	0	37, 107		26, 958	2, 912	1
42.00	04200 SUBPROVI DER 04300 NURSERY	0	32, 345	0	0	0	
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	027010		<u> </u>		10.00
50. 00	05000 OPERATING ROOM	0	169, 162	1	l '	8, 528	1
51. 00 54. 00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	92, 966	1	_	0 2, 600	
57. 00	05700 CT SCAN		17, 225	1	19, 024	156	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	8, 995			0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	20, 118	1		1, 040	
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY	0	94, 456	12, 742 0	l .	2, 912 0	1
60. 01	06002 RADIATION ONCOLOGY		0	Ö	· ·	0	1
65.00	06500 RESPI RATORY THERAPY	0	41, 493	4, 593	3, 021	2, 184	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	28, 276	1	27, 442	0	
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	31, 988 4, 794		5, 319 0	1, 404 1, 560	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	0	Ö	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	1	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
90.00	09000 CLINIC	0	9, 023	2, 832	2, 590	1, 040	90.00
91. 00	09100 EMERGENCY	0	146, 894	11, 086	207, 596	11, 648	
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 00 92. 01
92.01	OTHER REIMBURSABLE COST CENTERS	ı o	0	<u> </u>	0	0	92.01
95.00	09500 AMBULANCE SERVICES	0	50, 847	4, 153	42, 771	364	95. 00
440.00	SPECIAL PURPOSE COST CENTERS			1			440.00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	256, 097	1, 234, 711	190, 173	824, 374	54 964	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	200,071	1,201,711	170, 170	021,071	01,701	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	832				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS	10, 061	0	0	· ·		192. 00 192. 02
	19203 GREAT BEGINNINGS/MATERNAL	10,001	0	0	0		192. 02
192. 04	19204 LI FELI NE	0	0	0	0		192. 04
	19205 OWNED PROPERTIES	0	0	0	0		192. 05
	19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT	0	1, 730	342			192. 08 192. 09
	19214 BREAST PUMPS		0	0	· · · · · · · · · · · · · · · · · · ·		192. 10
	19209 LUNG CENTER	0	6, 649	0	0	0	192. 12
	19210 MGH PHYS PRACT MGMT	0	47, 183		_		192. 14
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	0	26, 210 0	0	_		192. 15 192. 16
	19217 MGH FMC SOUTH	0	Ō	Ö	1		192. 17
	19218 MGH FAIRM MED ASSOC	0	0	0	0		192. 18
	19219 MGH FMC MARION	0	14, 290	0	0		192. 19 193. 00
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD		0	0	1		193. 00
193. 02	19302 MGH FMC GAS CITY		0	Ö	o	0	193. 02
	19303 MGH HOSPI TALI STS	0	0	0	0		193. 03
	19304 MGH MAR FAM PRACT 19305 MGH FMC SWAYZEE	0	0	0	0		193. 04 193. 05
	19306 MGH PEDIATRIC CTR	0	17, 745		· ·		193. 06
	· · · · · ·	·		•			·

			T	06/30/2016	Date/Time Pre 11/23/2016 9:	pared:
Cost Center Description	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	23 alli
Cost Center Description	(MEALS SERVED)	(HOURS	PLANT	LINEN SERVICE	(HOURS OF	
	(WLALS SLIVED)	WORKED)	(SQUARE	(POUNDS OF	SERVICE)	
		WORKED)	FEET)	LAUNDRY)	SERVI CE)	
	6, 01	6. 02	7.00	8. 00	9. 00	
193. 07 19307 MGH SPECIALTY PHYS	0	4, 317				193. 07
193.08 19308 MGH FMC CONVERSE	o	0	0	0	0	193. 08
193.09 19309 MGH UPLAND HEALTH	o	0	0	0	0	193. 09
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	193. 11
193. 12 19312 OB/GYN	O	0	0	0	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	O	0	0	0	0	193. 15
194.00 07963 OTHER NONREIMBURSABLE	O	0	0	0	0	194. 00
194. 01 07950 MOW	o	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, 452	0	0	0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	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	0	0	194. 09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194. 10
194. 11 07960 FAI RMOUNT	0	0	0	0	0	194. 11
194. 12 07961 GAS CITY	0	0	0	0	0	194. 12
194. 13 07962 LYONS	0	0	0	0		194. 13
194. 14 07964 WABASH	0	0	0	0	0	194. 14
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 896, 220	1, 824, 541	10, 154, 280	745, 577	3, 360, 812	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 124415	1. 340471				
204.00 Cost to be allocated (per Wkst. B,	175, 702	169, 060	3, 081, 914	108, 132	197, 744	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 660142	0. 124207	16. 063181	0. 131146	3. 241918	205. 00
11)	1					l

	Financial Systems	MARIUN GENER		0011 450044 0		eu or Form CMS-2552-1
COST	ILLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 07/01/2015	Worksheet B-1
				1	0 06/30/2016	Date/Time Prepared: 11/23/2016 9: 25 am
	Cost Center Description	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
		(MEALS	ADMI NI STRATI ON		(COSTED	
		SERVED)	(DI RECT	SUPPLY (COSTED	REQUIS.)	
			NRSING HRS)	REQUIS.)		
	OFNEDAL CEDILOF OCCT OFNEDO	10.00	13. 00	14. 00	15. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	I	I			1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 0
5.00	00500 ADMINISTRATIVE & GENERAL					5. 0
6.00	00600 MAI NTENANCE & REPAI RS					6.0
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A					6. 0
7. 00	00700 OPERATION OF PLANT					7. 0
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG	04 445				9.00
10. 00 13. 00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON	91, 115	1			10.00
14. 00	01400 CENTRAL SERVICES & SUPPLY			10, 000		14. 0
15. 00	01500 PHARMACY	C	0	0		15. 0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0.45.000			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	51, 832 11, 040		2, 550 1, 000		
40. 00	04000 SUBPROVI DER - I PF	11,040	02, 100	1, 000	o	40. 0
41.00	04100 SUBPROVI DER - I RF	8, 794	37, 107	200	0	41. 0
42. 00	04200 SUBPROVI DER	C		0	0	
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	C	32, 345	0	0	43. 0
50. 00	05000 OPERATING ROOM		169, 162	1, 715	0	50.00
51.00	05100 RECOVERY ROOM	C		0	1	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	C	0	200	0	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0	0	0	57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION		20, 118		-	59. 0
60.00	06000 LABORATORY	C	0	600		
60. 01	06001 ONCOLOGY	C	0	25		60. 0
60. 02 65. 00	O6002 RADI ATI ON ONCOLOGY O6500 RESPI RATORY THERAPY	0	0 45, 323	550 550		60.00
66. 00	06600 PHYSI CAL THERAPY		28, 276		1	66. 0
69. 00	06900 ELECTROCARDI OLOGY	C	31, 988		0	69. 0
69. 01	06901 CARDI AC REHAB	C	4, 794	0	0	69. 0
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	C		0	0	71. 0
73. 00	07300 DRUGS CHARGED TO PATIENTS				-	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	C				
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	813	146, 894	1, 100	0	91. 0
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	C	0	0	0	
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVICES	C	50, 847	100	0	95. 0
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE					113. 0
118.00	1 1	72, 479	903, 206	8, 490	100	
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	-	
	19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS			1 0	0	l I
	19203 GREAT BEGINNINGS/MATERNAL	C	4, 324	Ö	O	192. 0
	19204 LI FELI NE	C	0	0	O	192. 0
	19205 OWNED PROPERTIES	C	0	0	0	192. 0
	19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT			0	0	192. 0 192. 0
	19214 BREAST PUMPS		o o	Ö	o	192. 10
	19209 LUNG CENTER	C	0	0	0	192. 13
	19210 MGH PHYS PRACT MGMT	C	0	0	0	192. 1
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC		0	285	0	192. 1! 192. 1
	19217 MGH FMC SOUTH		o o	200		192. 1
	19218 MGH FAIRM MED ASSOC		0	0	0	192. 1
	19219 MGH FMC MARI ON	C	0	200	0	192. 1
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD		0	0 25	0	193. 0 193. 0
	19302 MGH FMC NORTHWOOD			150		193. 0
193. 03	19303 MGH HOSPITALISTS	0	o	0	0	193. 0
	19304 MGH MAR FAM PRACT	C		300		
193.05	19305 MGH FMC SWAYZEE	C	0	25	0	193. 0

Provider CN: 150011 Period: From 07/01/2015 Date/Time Prepared: 11/23/2016 9:25 am	Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
To 06/30/2016 Date/Time Prepared: To 06/30/2016 Date/Time Prepared: T1/23/2016 9: 25 am PHARMACY (COSTED NRSI NG ADMINISTRATION SERVICES & SUPPLY (COSTED NRSI NG HRS) PHARMACY	COST ALLOCATION - STATISTICAL BASIS		Provi der			Worksheet B-1
11/23/2016 9: 25 am						D 1 (T) D
Cost Center Description					0 06/30/2016	
COSTED SERVED COSTED REQUIS.) COSTE	Cost Center Description	DIFTADV	MIIDSI MG	CENTRAL	DHADMACV	11/23/2010 4.25 alli
SERVED (DIRECT NRSING HRS) REQUIS. NRSING HRS) REQUIS. 193.06 19306 MCH PEDIATRIC CTR 0 13.00 14.00 15.00 193.06 193.07 1	cost center bescription					
10.00 13.00 14.00 15.00 19.306 19.306 19.306 19.306 19.306 19.306 19.307 19.307 19.307 19.307 19.307 19.307 19.307 19.308 19.309 19.30			ALDINITION OTTOTTO			
193. 06 19306 MGH PEDI ATRI C CTR 0 0 0 25 0 193. 06 193. 07 19307 MGH SPECI ALTY PHYS 0 0 0 0 0 193. 07 19307 MGH SPECI ALTY PHYS 0 0 0 0 0 193. 08 19308 MGH FMC CONVERSE 0 0 0 0 25 0 193. 08 193. 08 1938 MGH FMC CONVERSE 0 0 0 0 25 0 193. 08 193. 09 19309 MGH UPLAND HEALTH 0 0 0 0 0 0 193. 10 193. 10 19310 MGH MGH WOMENS CTR 0 0 0 0 0 193. 11 193. 11 19311 MGH MGH PSYCHI ATRY 0 0 0 0 0 0 193. 11 193. 12 19312 096/GVN 0 0 0 0 0 0 193. 11 19315 19315 MGH RIVER VIEW BLDG 0 0 0 0 0 193. 15 19315 MGH RIVER VIEW BLDG 0 0 0 0 0 194. 00 194. 00 194. 00 19750 MCW 9,556 0 0 0 0 194. 00 194. 10		0225)	(DI RECT		112401017	
193. 06 19306 MGH PEDIATRIC CTR			`	•		
193. 07 19307 MGH SPECIALTY PHYS 0 0 0 25 0 193. 07 193.08 19308 MGH FMC CONVERSE 0 0 0 25 0 193. 08 19309 MGH UPLAND HEALTH 0 0 0 225 0 193. 09 193. 09 19309 MGH UPLAND HEALTH 0 0 0 225 0 193. 09 193. 10 193. 10 193. 10 193. 10 MGH MGH WOMENS CTR 0 0 0 0 0 193. 10 193. 11 19311 MGH MGH PSYCHIATRY 0 0 0 0 0 0 193. 11 19312 MGH MGH PSYCHIATRY 0 0 0 0 0 0 193. 11 193. 12 19312 MGH RIVER VIEW BLDG 0 0 0 0 0 193. 11 193. 15 19315 MGH RI VER VIEW BLDG 0 0 0 0 0 0 193. 15 194. 00 07963 OTHER NONREI MBURSABLE 0 0 0 0 0 0 194. 00 194. 01 194. 01 194. 02 07951 MENTAL HEALTH 9,080 0 0 0 0 194. 01 194. 02 07951 MENTAL HEALTH 9,080 0 0 0 0 194. 02 194. 03 07952 ADVERTI SI NG 0 0 0 0 194. 02 194. 03 07952 ADVERTI SI NG 0 0 0 0 194. 04 194. 05 07954 MGH TAYLOR UNI VERSI TY 0 0 0 0 0 194. 04 194. 05 07954 MGH TAYLOR UNI VERSI TY 0 0 0 0 0 194. 08 194. 09 07958 MGH AMBUCARE BLDG 0 0 0 0 194. 08 194. 09 194. 10 07959 MGH 106 LYONS BLDG 0 0 0 0 0 194. 10 194. 10 107960 MGH SMD BLDG 0 0 0 0 0 194. 10 194. 10 107960 MGH SMD BLDG 0 0 0 0 0 194. 10 194. 10 107960 MGH SMD BLDG 0 0 0 0 0 194. 10 194. 11 107960 FAIR MGH SMD BLDG 0 0 0 0 0 194. 11 194. 12 107961 GAS CITY 0 0 0 0 0 0 194. 12 194. 13 07962 LYONS BLDG 0 0 0 0 0 0 194. 12 194. 13 07962 LYONS BLDG 0 0 0 0 0 0 194. 12 194. 13 07962 LYONS BLDG 0 0 0 0 0 0 194. 12 194. 13 07962 LYONS BLDG 0 0 0 0 0 0 194. 12 194. 13 07962 LYONS BLDG 0 0 0 0 0 0 194. 12 194. 13 07962 LYONS BLDG 0 0 0 0 0 0 194. 12 194. 14 07964 WABASH 0 0 0 0 0 0 0 0 194. 12 194. 14 07964 WABASH 0 0 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		10.00			15.00	
193. 08 19308 MGH FMC CONVERSE	193. 06 19306 MGH PEDIATRIC CTR	0	0	25	0	193. 06
193. 09 19309 MGH UPLAND HEALTH 0 0 0 0 225 0 193. 09 193. 10 19310 MGH MGH WOMENS CTR 0 0 0 0 0 0 193. 11 193. 12 193. 11 19311 MGH MGH WOMENS CTR 0 0 0 0 0 0 193. 11 193. 12 193. 12 193. 12 193. 12 193. 12 193. 12 193. 12 193. 12 193. 12 193. 12 193. 12 193. 12 193. 15 193. 15 193. 15 193. 15 MGH RI VER VIEW BLDG 0 0 0 0 0 0 193. 15 194. 00 07963 OTHER NONREI MBURSABLE 0 0 0 0 0 0 194. 01 194. 01 194. 02 194. 01 195. 18 195. 195. 195. 195. 195. 195. 195. 195.	193.07 19307 MGH SPECIALTY PHYS	o	o	C	o	193. 07
193. 10 19310 MGH MGH WOMENS CTR	193.08 19308 MGH FMC CONVERSE	o	o	25	0	193. 08
193. 11 19311 19311 19311 19312 19312 0B/GYN	193.09 19309 MGH UPLAND HEALTH	0	0	225	0	193. 09
193. 12 19312 0B/GYN	193.10 19310 MGH MGH WOMENS CTR	0	0	C	0	193. 10
193. 15	193. 11 19311 MGH MGH PSYCHIATRY	0	0	C	0	193. 11
194. 00 07963 OTHER NONREIMBURSABLE 0 0 0 0 0 194. 00 194. 01 194. 02 194. 01 07950 MOW 9, 556 0 0 0 0 194. 01 194. 01 194. 02 07951 MENTAL HEALTH 9, 080 0 0 0 194. 02 194. 03 07952 MGH WORK SOLUTIONS 0 0 0 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 0 194. 09 194. 10 07958 MGH AMBUCARE BLDG 0 0 0 0 194. 10 194. 10 194. 11 07960 FAI RMOUNT 0 0 0 0 0 194. 11 10 194. 12 10 194. 13 07962 LYONS 0 0 0 0 0 0 194. 13 10 194. 14 10 194. 12 194. 14 07964 WABASH 0 0 0 0 0 0 194. 13 10 194. 14 10 196. 14 10	193. 12 19312 OB/GYN	0	0	C	0	193. 12
194. 01 07950 MOW 9,556 0 0 0 0 194. 01 194. 02 07951 MENTAL HEALTH 9,080 0 0 0 194. 02 194. 03 07952 ADVERTI SI NG 0 0 0 194. 03 194. 04 07953 MGH WORK SOLUTI ONS 0 0 0 194. 03 194. 04 07953 MGH TAYLOR UNIVERSITY 0 0 0 0 0 194. 05 194. 08 07957 MGH SMMP BLDG 0 0 0 0 194. 08 194. 09 07958 MGH AMBUCARE BLDG 0 0 0 0 194. 09 194. 10 07959 MGH 106 LYONS BLDG 0 0 0 0 194. 10 194. 11 07960 FAI RMOUNT 0 0 0 0 194. 11 194. 12 07961 GAS CI TY 0 0 0 0 0 194. 12 194. 13 07962 LYONS 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 194. 14 200. 00 201. 00 Negati ve Cost Centers Cost to be all ocated (per Wkst. B, Part I)	193.15 19315 MGH RIVER VIEW BLDG	0	0	C	0	193. 15
194. 02 07951 MENTAL HEALTH 9, 080 0 0 0 194. 02 194. 03 07952 ADVERTISING 0 0 0 194. 03 194. 04 07953 MGH WORK SOLUTIONS 0 0 0 194. 04 194. 05 07957 MGH SMMP BLDG 0 0 0 0 194. 05 194. 09 07958 MGH SMMP BLDG 0 0 0 0 194. 09 194. 10 194. 10 194. 11 07960 FAI RMOUNT 0 0 0 0 194. 11 194. 12 07961 GAS CITY 0 0 0 0 0 194. 12 194. 14 07964 WABASH 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 0 194. 14 020. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194.00 07963 OTHER NONREI MBURSABLE	0	0	C	0	194. 00
194. 03 07952 ADVERTISING 194. 04 07953 MGH WORK SOLUTIONS 194. 05 07954 MGH TAYLOR UNIVERSITY 0 0 0 0 0 194. 05 194. 08 07957 MGH SMMP BLDG 0 0 0 0 0 0 194. 08 194. 09 07958 MGH AMBUCARE BLDG 0 0 0 0 0 0 194. 08 194. 10 07959 MGH 106 LYONS BLDG 0 0 0 0 0 194. 10 194. 11 07960 FAI RMOUNT 0 0 0 0 0 194. 11 194. 12 07961 GAS CITY 0 0 0 0 0 0 194. 12 194. 13 07962 LYONS 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 194. 13 194. 14 07964 Cross Foot Adjustments 0 0 0 0 0 0 194. 14 200. 00 0 0 0 0 0 0 194. 14 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		9, 556	0	C	0	194. 01
194. 04 07953 MGH WORK SOLUTIONS 194. 05 07954 MGH TAYLOR UNIVERSITY 0 0 0 0 0 0 194. 05 194. 08 07957 MGH SMMP BLDG 0 0 0 0 0 0 194. 08 194. 09 07958 MGH AMBUCARE BLDG 0 0 0 0 0 0 194. 09 194. 10 07959 MGH 106 LYONS BLDG 0 0 0 0 0 0 194. 10 194. 12 07961 GAS CITY 0 0 0 0 0 0 194. 11 194. 12 07961 Cross Foot Adj ustments 200. 00 202. 00 Cost to be allocated (per Wkst. B, Part I) 194. 194. 1850 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 02 07951 MENTAL HEALTH	9, 080	0	C	0	194. 02
194. 05 07954 MGH TAYLOR UNI VERSITY 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. 10 194. 11 107960 FAI RMOUNT 0 0 0 0 0 194. 11 194. 12 07961 GAS CITY 0 0 0 0 0 194. 12 194. 13 07962 LYONS 0 0 0 0 0 194. 13 194. 14 07964 Cross Foot Adjustments 0 0 0 0 0 0 194. 14 07964 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 03 07952 ADVERTI SI NG	0	0		1 9	194. 03
194. 08 07957 MGH SMMP BLDG	194. 04 07953 MGH WORK SOLUTIONS	0	0	50	0	
194. 09 07958 MGH AMBUCARE BLDG 0 0 0 0 194. 09 194. 10 07959 MGH 106 LYONS BLDG 0 0 0 0 0 194. 10 194. 11 07960 FAI RMOUNT 0 0 0 0 0 194. 11 194. 12 07961 GAS CITY 0 0 0 0 0 194. 12 194. 13 07962 LYONS 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 194. 14 0200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0	C	0	194. 05
194. 10 07959 MGH 106 LYONS BLDG 0 0 0 0 194. 10 194. 11 07960 FAI RMOUNT 0 0 0 0 194. 11 194. 12 07961 GAS CITY 0 0 0 0 0 194. 12 194. 13 07962 LYONS 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 194. 14 200. 00 Variable Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 8, 455, 244 202. 00	194.08 07957 MGH SMMP BLDG	0	0	C	0	194. 08
194. 11 07960 FAI RMOUNT 0 0 0 0 0 194. 11 194. 12 07961 GAS CITY 0 0 0 0 0 194. 12 194. 13 07962 LYONS 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 194. 14 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) R1, 287, 230 1, 811, 383 1, 029, 310 8, 455, 244 202. 00	194.09 07958 MGH AMBUCARE BLDG	0	0	C	0	
194. 12 07961 GAS CITY 0 0 0 0 0 194. 12 194. 13 07962 LYONS 0 0 0 0 0 194. 13 194. 14 107964 WABASH 0 0 0 0 0 0 194. 14 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) R11, 383 1, 029, 310 8, 455, 244 202. 00	194. 10 07959 MGH 106 LYONS BLDG	0	0	C	0	194. 10
194. 13 07962 LYONS 0 0 0 0 0 194. 13 194. 14 07964 WABASH 0 0 0 0 0 0 0 194. 14 200. 00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 1, 287, 230 1, 811, 383 1, 029, 310 8, 455, 244 202. 00		0	0	C	0	
194.14 07964 WABASH 0 0 0 0 0 194.14 200.00 201.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 1,287,230 1,811,383 1,029,310 8,455,244		0	0	C	0	
200.00		0	0	C	0	
201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 1,287,230 1,811,383 1,029,310 8,455,244 202.00	194. 14 07964 WABASH	0	0	C	0	1
202.00 Cost to be allocated (per Wkst. B, 1,287,230 1,811,383 1,029,310 8,455,244 202.00						
Part I)	1 1 3					
		1, 287, 230	1, 811, 383	1, 029, 310	8, 455, 244	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 14.127531 1.995948 102.931000 84,552.440000 203.00						
204.00 Cost to be allocated (per Wkst. B, 332,000 67,895 131,349 284,056 204.00		332, 000	67, 895	131, 349	284, 056	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part 3.643747 0.074813 13.134900 2,840.560000 205.00		3. 643747	0. 074813	13. 134900	2, 840. 560000	205. 00
	11)	l				I

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 07/01/2015 Part I
		T- 0/ /20 /201/ D-+- /T: D

				0 06/30/2016	Date/Time Pre	pared: 25 am
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	18, 642, 809		18, 642, 809	0	18, 642, 809	30. 00
31.00 03100 INTENSIVE CARE UNIT	6, 170, 877		6, 170, 877	0	6, 170, 877	31.00
40. 00 04000 SUBPROVI DER - 1 PF	0		0	o	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	3, 878, 553		3, 878, 553	o	3, 878, 553	41. 00
42. 00 04200 SUBPROVI DER	0		0	o	0	42. 00
43. 00 04300 NURSERY	2, 287, 535		2, 287, 535	l ol	2, 287, 535	43.00
ANCILLARY SERVICE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,	·	, , , , , , , , , , , , , , , , , , , ,	
50. 00 05000 OPERATING ROOM	19, 792, 061		19, 792, 061	0	19, 792, 061	50.00
51.00 05100 RECOVERY ROOM	0		0	o	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 155, 638		9, 155, 638	o	9, 155, 638	54.00
57. 00 05700 CT SCAN	1, 434, 915		1, 434, 915	o	1, 434, 915	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	841, 866		841, 866	o	841, 866	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 532, 335		3, 532, 335	o	3, 532, 335	59. 00
60. 00 06000 LABORATORY	10, 909, 128		10, 909, 128	o	10, 909, 128	60.00
60. 01 06001 0NC0L0GY	2, 399, 034		2, 399, 034	o	2, 399, 034	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0		0	o	0	60. 02
65. 00 06500 RESPIRATORY THERAPY	3, 710, 173	0	3, 710, 173	ol	3, 710, 173	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 635, 901	0	3, 635, 901	ol	3, 635, 901	66. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 364, 213		2, 364, 213	o	2, 364, 213	
69. 01 06901 CARDI AC REHAB	458, 090		458, 090		458, 090	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	أم	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	o	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	13, 346, 376		13, 346, 376	o	13, 346, 376	73. 00
OUTPATIENT SERVICE COST CENTERS	10,010,070		10,010,070	<u> </u>	10, 010, 070	70.00
90. 00 09000 CLINIC	1, 011, 780		1, 011, 780	O	1, 011, 780	90. 00
91. 00 09100 EMERGENCY	10, 219, 054		10, 219, 054		10, 219, 054	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 226, 979		3, 226, 979		3, 226, 979	
92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART)	0,220,777		0,220,777		0,220,777	92. 01
OTHER REIMBURSABLE COST CENTERS	-	L	· · · · · ·	-1		
95. 00 09500 AMBULANCE SERVI CES	2, 532, 853		2, 532, 853	0	2, 532, 853	95. 00
SPECIAL PURPOSE COST CENTERS	,	·	, , , , , , , , , , , , , , , , , , , ,	·	, ,	
113.00 11300 INTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	119, 550, 170	0	119, 550, 170	o	119, 550, 170	200. 00
201.00 Less Observation Beds	3, 226, 979		3, 226, 979		3, 226, 979	201. 00
202.00 Total (see instructions)	116, 323, 191	0	116, 323, 191	o	116, 323, 191	202. 00

Date/Time Prepared: 06/30/2016 11/23/2016 9:25 am 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 17. 462. 687 17, 462, 687 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 8, 753, 414 8, 753, 414 31.00 04000 SUBPROVIDER - IPF 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 4, 012, 478 4, 012, 478 41.00 04200 SUBPROVI DER 42.00 42.00 2, <u>402, 568</u> 43.00 04300 NURSERY 2, 402, 568 43.00 ANCILLARY SERVICE COST CENTERS 63, 747, 604 50.00 05000 OPERATING ROOM 0.196080 0.000000 50.00 37, 191, 178 100, 938, 782 05100 RECOVERY ROOM 51.00 0.000000 0.000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 655, 775 24, 405, 386 26, 061, 161 0.351314 0.000000 54.00 57.00 05700 CT SCAN 4, 313, 849 26, 639, 679 30, 953, 528 0.046357 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 277, 223 3, 610, 520 0.233170 0.000000 58.00 333, 297 58.00 05900 CARDIAC CATHETERIZATION 59.00 3, 013, 460 6,055,655 9, 069, 115 0.389491 0.000000 59.00 06000 LABORATORY 2, 834, 336 10, 247, 307 13, 081, 643 0.833926 0.000000 60.00 60.00 5, 823, 164 60.01 06001 ONCOLOGY 34,063 5, 857, 227 0.409585 0.000000 60.01 06002 RADIATION ONCOLOGY 0.000000 60.02 0.000000 60.02 65.00 06500 RESPIRATORY THERAPY 2, 879, 815 5, 155, 711 8, 035, 526 0.461721 0.000000 65.00 06600 PHYSI CAL THERAPY 5, 795, 905 4, 401, 796 10, 197, 701 0. 356541 0.000000 66.00 66.00 06900 ELECTROCARDI OLOGY 3, 597, 945 6, 081, 701 9, 679, 646 0. 244246 0.000000 69.00 69.00 06901 CARDI AC REHAB 69.01 0 777, 186 777, 186 0.589421 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 0.000000 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 7, 633, 880 57, 633, 386 65, 267, 266 0.204488 0.000000 73 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 629, 837 629, 837 1. 606416 0.000000 90.00 9, 779, 991 91.00 09100 EMERGENCY 57, 182, 777 66, 962, 768 0. 152608 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.599164 92.00 92.00 333, 842 5, 051, 958 5, 385, 800 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, 339, 127 4, 339, 127 0.583724 0.000000 95 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 112, 028, 483 281, 449, 497 393, 477, 980 200.00 201.00 Less Observation Beds 201. 00

112, 028, 483

281, 449, 497

393, 477, 980

202.00

202.00

Total (see instructions)

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/23/2016 9:25 am

			10 00/30/2010	11/23/2016 9: 25 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - 1 PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 196080			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 351314			54.00
57.00 05700 CT SCAN	0. 046357			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 233170			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 389491			59. 00
60. 00 06000 LABORATORY	0. 833926			60.00
60. 01 06001 0NCOLOGY	0. 409585			60. 01
60. 02 06002 RADIATION ONCOLOGY	0. 000000			60. 02
65. 00 06500 RESPI RATORY THERAPY	0. 461721			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 356541			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 244246			69. 00
69. 01 06901 CARDI AC REHAB	0. 589421			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. 204488			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	1. 606416			90.00
91. 00 09100 EMERGENCY	0. 152608			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 599164			92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 583724			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150011		Worksheet C
		From 07/01/2015	

				T	0 06/30/2016	Date/Time Pre	pared:
			Ti t	le XIX	Hospi tal	Cost	20 4111
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	18, 642, 809		18, 642, 809	0	18, 642, 809	30.00
31. 00	03100 INTENSIVE CARE UNIT	6, 170, 877		6, 170, 877			
40.00	04000 SUBPROVI DER - I PF	0		0	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	3, 878, 553		3, 878, 553	0	3, 878, 553	
42. 00	04200 SUBPROVI DER	0		0	0	0	1
43. 00	04300 NURSERY	2, 287, 535		2, 287, 535	0	2, 287, 535	
.0.00	ANCILLARY SERVICE COST CENTERS	2,20,,000		2/20//000		2/20//000	10.00
50.00	05000 OPERATING ROOM	19, 792, 061		19, 792, 061	0	19, 792, 061	50.00
51. 00	05100 RECOVERY ROOM	0		0			51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 155, 638		9, 155, 638	_	9, 155, 638	
57. 00	05700 CT SCAN	1, 434, 915		1, 434, 915		1, 434, 915	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	841, 866		841, 866		841, 866	
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 532, 335		3, 532, 335		3, 532, 335	
60. 00	06000 LABORATORY	10, 909, 128		10, 909, 128		10, 909, 128	
60. 01	06001 ONCOLOGY	2, 399, 034		2, 399, 034			
60. 01	06002 RADI ATI ON ONCOLOGY	2, 377, 034		2, 377, 034	0	2, 377, 034	60.01
65. 00	06500 RESPIRATORY THERAPY	3, 710, 173	0	3, 710, 173	0	3, 710, 173	
66. 00	06600 PHYSI CAL THERAPY	3, 635, 901	0	3, 635, 901		3, 635, 901	
69. 00	06900 ELECTROCARDI OLOGY	2, 364, 213	0	2, 364, 213		2, 364, 213	
69. 00	06901 CARDI AC REHAB						
		458, 090		458, 090		458, 090	
71.00		0		0	0	1	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	10 04/ 07/		10 04/ 07/	0	1	72.00
73. 00		13, 346, 376		13, 346, 376	0	13, 346, 376	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	4 044 700		1 044 700		4 044 700	00.00
90.00	09000 CLI NI C	1, 011, 780		1, 011, 780			
91. 00	09100 EMERGENCY	10, 219, 054		10, 219, 054		10, 219, 054	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 226, 979		3, 226, 979		3, 226, 979	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS		Г	T	T		
95. 00		2, 532, 853		2, 532, 853	0	2, 532, 853	95. 00
	SPECIAL PURPOSE COST CENTERS			T	T		
	11300 INTEREST EXPENSE	110 550 :	_	440 550 :	_	l .	113. 00
200.00		119, 550, 170	l e	, ,		, ,	
201.00		3, 226, 979	l e	3, 226, 979		3, 226, 979	
202.00	Total (see instructions)	116, 323, 191	0	116, 323, 191	0	116, 323, 191	202. 00

					rom 07/01/2015 o 06/30/2016	Part I Date/Time Pre 11/23/2016 9:	pared:
			Ti t	le XIX	Hospi tal	Cost	25 alli
			Charges	I C XIX	1105pr tur	0031	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00	03000 ADULTS & PEDIATRICS	17, 462, 687		17, 462, 687			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	8, 753, 414		8, 753, 414			31. 00
40.00	04000 SUBPROVI DER - I PF	0		0			40.00
41.00	04100 SUBPROVI DER - I RF	4, 012, 478		4, 012, 478			41.00
42.00	04200 SUBPROVI DER	0		l c			42. 00
43.00	04300 NURSERY	2, 402, 568		2, 402, 568			43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	37, 191, 178	63, 747, 604	100, 938, 782	0. 196080	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0	0	C	0.000000	0.000000	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 655, 775	24, 405, 386	26, 061, 161	0. 351314	0.000000	54. 00
57.00	05700 CT SCAN	4, 313, 849	26, 639, 679	30, 953, 528	0. 046357	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	333, 297	3, 277, 223	3, 610, 520		0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 013, 460	6, 055, 655			0.000000	
60.00	06000 LABORATORY	2, 834, 336	10, 247, 307			0.000000	
60. 01	06001 ONCOLOGY	34, 063	5, 823, 164	5, 857, 227		0.000000	
60. 02	06002 RADI ATI ON ONCOLOGY	0	0	C	0. 000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	2, 879, 815	5, 155, 711	8, 035, 526		0. 000000	
66.00	06600 PHYSI CAL THERAPY	5, 795, 905	4, 401, 796			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	3, 597, 945	6, 081, 701	9, 679, 646		0. 000000	
69. 01	06901 CARDI AC REHAB	0	777, 186			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(5.0.7.0	0.000000	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 633, 880	57, 633, 386	65, 267, 266	0. 204488	0. 000000	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		(20, 027	(20.027	1 (0(41)	0.000000	00.00
	09000 CLINIC 09100 EMERGENCY	0 770 001	629, 837			0.000000	
		9, 779, 991	57, 182, 777			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	333, 842	5, 051, 958			0.000000	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	C	0. 000000	0. 000000	92. 01
05 00	09500 AMBULANCE SERVICES	l ol	4, 339, 127	4, 339, 127	0. 583724	0. 000000	95. 00
95.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	4, 339, 127	4, 339, 127	0. 363724	0.00000	95.00
113 00	11300 I NTEREST EXPENSE						113. 00
200.00		112, 028, 483	281, 449, 497	393, 477, 980			200. 00
201.00	,	112, 020, 403	201, 477, 477	373, 477, 700			201.00
202. 00		112, 028, 483	281, 449, 497	393, 477, 980			202. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150011	From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/23/2016 9:25 am	

				11/23/2016 9:25 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
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 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 0NCOLOGY	0. 000000			60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000			60. 02
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01 06901 CARDI AC REHAB	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1=02.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS			Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/23/2016 9:	pared: 25 am
		Ti tl	e XVIII	Hospi tal PPS		
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 619, 284	0	2, 619, 28	16, 592	157. 86	30.00
31.00 INTENSIVE CARE UNIT	646, 487		646, 48	4, 309	150. 03	31.00
40. 00 SUBPROVI DER - I PF	C	0)	0 0	0.00	40.00
41. 00 SUBPROVI DER - I RF	555, 317	0	555, 31	7 3, 086	179. 95	41. 00
42. 00 SUBPROVI DER	C	0)	0 0	0.00	42. 00
43. 00 NURSERY	44, 107		44, 10	7 2, 045	21.57	43.00
200.00 Total (lines 30-199)	3, 865, 195		3, 865, 19	5 26, 032		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 946	1, 096, 496	,			30. 00
31.00 INTENSIVE CARE UNIT	1, 919	287, 908				31.00
40. 00 SUBPROVI DER - I PF	C	O)			40. 00
41. 00 SUBPROVI DER - I RF	2, 518	453, 114				41. 00
42. 00 SUBPROVI DER	C	0				42. 00
43. 00 NURSERY		o c				43.00
200.00 Total (lines 30-199)	11, 383	1, 837, 518				200. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Peri od:	Worksheet D	
				From 07/01/2015		
				To 06/30/2016	Date/Time Pre 11/23/2016 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total 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)	
	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, 949, 780	100, 938, 782	0. 01931	6 14, 399, 079	278, 133	50.00
51. 00 05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 132, 902	26, 061, 161	0. 04347	1 939, 021	40, 820	54.00
57. 00 05700 CT SCAN	98, 164	30, 953, 528	0. 00317	1 2, 550, 843	8, 089	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	97, 144	3, 610, 520	0. 02690	6 192, 684	5, 184	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	297, 721	9, 069, 115	0. 03282	8 1, 101, 992	36, 176	59. 00
	1		1		l	

782, 035

293, 201

113, 462

419, 233

72, 224

347, 964

152, 089

780, 099

453, 384

7, 030, 306

0

0

40, 904

13, 081, 643

5, 857, 227

8, 035, 526

9, 679, 646

65, 267, 266

66, 962, 768

5, 385, 800

356, 507, 706

777, 186

629, 837

10, 197, 701

0.059781

0.006984

0.000000

0.036488

0.011126

0.043311

0.092930

0.000000

0.000000

0.005331

0. 241474

0.011650

0.084181

0.000000

1, 519, 080

1, 513, 844

1, 945, 166

1, 993, 395

3, 768, 830

4, 650, 069

34, 896, 194

300, 263

0

0

21, 928

90, 812

55, 237

21, 642

86, 336

20, 092

54, 173

25, 276

0 69.01

0

0

722, 123 200. 00

153

60.00

60 01

60.02

65.00

66.00

69 00

71.00

72.00

73.00

90.00

91.00

92.00

92.01

95.00

60.00

60 01

60.02

65.00

66.00

69 00

69.01

71.00

72 00

73.00

90.00

91.00

92.00

92.01

200.00

06000 LABORATORY

06002 RADIATION ONCOLOGY

06600 PHYSI CAL THERAPY

06900 ELECTROCARDI OLOGY

06901 CARDI AC REHAB

06500 RESPIRATORY THERAPY

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

09201 OBSERVATION BEDS (DISTINCT PART)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

06001 ONCOLOGY

09000 CLI NI C

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	MARION GENERA	AL HOSPITAL		In lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER		rs Provi der	1	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part III Date/Time Pre 11/23/2016 9:	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos	Swing-Bed Adjustment t Amount (see	Total Costs (sum of cols. 1 through 3,	
				instructions)	minus col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					1	
30. 00 03000 ADULTS & PEDI ATRI CS	0	_	1	0		
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	0	
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	0			0	0	
42. 00 04200 SUBPROVI DER - 1 RF	0					
43. 00 04300 NURSERY	0	0			0	
200.00 Total (lines 30-199)	0	Ö		Ö		200. 00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program	PSA Adj. Nursing School	
	buys	0 1 001 1 0)	Trogram bays	Pass-Through Cost (col. 7 x		
				cost (cor. 7 x		
	6.00	7. 00	8.00	9. 00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS				•	<u> </u>	
30. 00 03000 ADULTS & PEDI ATRI CS	16, 592					
31.00 03100 INTENSIVE CARE UNIT	4, 309	0.00			·	
40. 00 04000 SUBPROVI DER - PF	0	0.00		0	0	1
41. 00 04100 SUBPROVI DER -	3, 086		1		0	
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0 2, 045		1	0 0	1	
200. 00 Total (lines 30-199)	26, 032		11, 38	٠	_	200. 00
Cost Center Description	PSA Adj .	PSA Adj. All	11, 30	31 0		200.00
р	Allied Health					
		Education Cost				
	12.00	13. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0		•			30.00
31. 00 03100 INTENSIVE CARE UNIT	0	_	•			31.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	0	0	1			40.00
42. 00 04200 SUBPROVI DER	0	_	1			42.00
43. 00 04300 NURSERY	0		•			43. 00
200.00 Total (lines 30-199)	0		1			200. 00
	1	٠	1			,

Heal th	Financial Systems	MARION GENER	AI HOSPITAI		In lie	eu of Form CMS-:	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provi der	F	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Pre 11/23/2016 9:	pared:
	,			e XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
		4.00	0.00	0.00	4.00	4)	
	ANOLLI ARV CERVI OF COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS						F0 00
	05000 OPERATI NG ROOM	0			0	0	50.00
	05100 RECOVERY ROOM	0	0		0	0	51.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	05700 CT SCAN	0	0		0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
	06000 LABORATORY	0	0	(0	0	60.00
	06001 ONCOLOGY	0	0	(0	0	60. 01
	06002 RADI ATI ON ONCOLOGY	0	0	(0	0	60. 02
	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
	06901 CARDI AC REHAB	0	0	(0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	(0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(0	0	90. 00
	09100 EMERGENCY	0	0	(0	0	91. 00
00 00	COCCO ODCEDIATION DEDC (NON DICTINGT DADT)						1 00 00

0 0 0

0

0 0 0

0 0 0

0 0 92. 01

91. 00 92. 00 0

95. 00 0 200. 00

Health Financial Systems	MARION GENER				u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od: From 07/01/2015	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2016		pared:
					11/23/2016 9:	
			le XVIII	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cos		Inpati ent	
		(from Wkst. C		Ratio of Cost	Program	
	Cost (sum of		(col . 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
	4)	7.00	0.00	7)	10.00	
ANCILLARY CERVICE COCT CENTERS	6.00	7.00	8.00	9. 00	10.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1 0	100, 938, 78	2 0.00000	0.00000	14, 399, 079	50.00
51. 00 05100 RECOVERY ROOM		100, 930, 70	0.00000			1
54. 00 05100 RECOVERT ROOM 54. 00 05400 RADI OLOGY - DI AGNOSTI C		26, 061, 16	1			
57. 00 05700 CT SCAN		30, 953, 52	1			
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		3, 610, 52	1			
59. 00 05900 CARDI AC CATHETERI ZATI ON		9, 069, 11	1			
60. 00 06000 LABORATORY		13, 081, 64	1			
60. 01 06001 0NCOLOGY		5, 857, 22	1			
60. 02 06002 RADI ATI ON ONCOLOGY		3,037,22	0.00000			60.01
65. 00 06500 RESPI RATORY THERAPY		8, 035, 52	1			
66. 00 06600 PHYSI CAL THERAPY		10, 197, 70	1			
69. 00 06900 ELECTROCARDI OLOGY		9, 679, 64				
69. 01 06901 CARDI AC REHAB		777, 18				1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		,,,,,	0.00000		-	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 00000			
73. 00 07300 DRUGS CHARGED TO PATIENTS		65, 267, 26	1			
OUTPATIENT SERVICE COST CENTERS		00/20//20	0, 00000	0.00000	0,700,000	70.00
90. 00 09000 CLINIC	C	629, 83	7 0.00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	i c	1				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		5, 385, 80	1			
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	C	1	0.00000			1
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)		356, 507, 70	, l		34, 896, 194	200

Health Financial Systems	MARION GENERAL HO	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am

			1	o 06/30/2016	Date/lime Prep 11/23/2016 9:3	
		Ti tl	e XVIII	Hospi tal	PPS	20 4
Cost Center Description	I npati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
	Program	Program	Program	Physi ci an	Nursing School	
	Pass-Through	Charges	Pass-Through	Anestheti st		
	Costs (col. 8		Costs (col. 9	Cost		
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00	21. 00	22. 00	
ANCILLARY SERVICE COST CENTERS				1		
50.00 05000 OPERATING ROOM	0	14, 759, 728	3 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	7, 732, 560	1	0	0	54.00
57.00 05700 CT SCAN	0	7, 740, 619		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 013, 269		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	2, 831, 193		0	0	59. 00
60. 00 06000 LABORATORY	0	1, 760, 011		0	0	60.00
60. 01 06001 0NCOLOGY	0	2, 546, 385	5 0	0	0	60. 01
60. 02 06002 RADIATION ONCOLOGY	0	0	0	0	0	60. 02
65. 00 06500 RESPI RATORY THERAPY	0	1, 713, 691		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	25, 692	1	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 025, 219	0	0	0	69. 00
69. 01 06901 CARDI AC REHAB	0	359, 536	0	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	28, 789, 622	2 0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	297, 657	1	0	0	90. 00
91. 00 09100 EMERGENCY	0	11, 777, 017	1	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 108, 372	2 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 SERVI CES						95. 00
200.00 Total (lines 50-199)	0	84, 480, 571	0	0	0	200. 00

Health Financial Systems	MARION GENERAL HO	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am

					11/23/2016 9:	25 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	PSA Adj . P	SA Adj. All				
	Allied Health Of	ther Medical				
	Ed	lucation 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	o				65.00
66. 00 06600 PHYSI CAL THERAPY	O	o				66.00
69. 00 06900 ELECTROCARDI OLOGY	o	o				69. 00
69. 01 06901 CARDI AC REHAB	o	o				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	o				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	o				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	O	o				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	o				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	O	o				92. 01
OTHER REIMBURSABLE COST CENTERS	<u> </u>					
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	o				200. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST			Period: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/23/2016 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 196080			0	2, 894, 087	50.00
51.00 05100 RECOVERY ROOM	0. 000000		l .	0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 351314	7, 732, 560		0	2, 716, 557	54.00
57. 00 05700 CT SCAN	0. 046357			0	358, 832	57. 00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 233170	1, 013, 269		0	236, 264	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 389491	2, 831, 193		0	1, 102, 724	59. 00
60. 00 06000 LABORATORY	0. 833926	1, 760, 011	1, 46	2 0	1, 467, 719	60.00
60. 01 06001 0NCOLOGY	0. 409585	2, 546, 385		0	1, 042, 961	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000	0)	0	0	60. 02
65. 00 06500 RESPIRATORY THERAPY	0. 461721	1, 713, 691		0	791, 247	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 356541	25, 692		0	9, 160	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 244246			0	494, 652	69. 00
69. 01 06901 CARDI AC REHAB	0. 589421	359, 536	,	0	211, 918	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	1	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0)	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 204488	28, 789, 622		0 34, 269	5, 887, 132	73. 00
OUTPATIENT SERVICE COST CENTERS	•					
90. 00 09000 CLI NI C	1. 606416	297, 657		0 0	478, 161	90.00
91. 00 09100 EMERGENCY	0. 152608	11, 777, 017		0	1, 797, 267	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 599164	1, 108, 372		0	664, 097	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	1	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	,		,			1
95. 00 09500 AMBULANCE SERVI CES	0. 583724			0		95. 00
200.00 Subtotal (see instructions)		84, 480, 571	1, 46	2 34, 269	20, 152, 778	200.00
201.00 Less PBP Clinic Lab. Services-Program			,	0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		84, 480, 571	1, 46	2 34, 269	20, 152, 778	202. 00

Health Financial Systems		HOSPI TAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND V	VACCINE COST	Provi der CO	CN: 150011	From 07/01/2015	Worksheet D Part V Date/Time Prep 11/23/2016 9:2	
			Title	XVIII	Hospi tal	PPS	
		Costs					

				10 06/30/2016	11/23/2016 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subj ect To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLLI ADV. CEDVI OF COCT. OFNITEDO	6. 00	7. 00				_
ANCILLARY SERVICE COST CENTERS	1		1			
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 I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1 210	0				59. 00
60. 00 06000 LABORATORY 60. 01 06001 0NCOLOGY	1, 219	0				60.00
	0	0				60. 01 60. 02
60. 02 06002 RADI ATI ON ONCOLOGY 65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY		0				66. 00
69. 00 06900 ELECTROCARDI OLOGY		0				69. 00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS						72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	7, 008				73. 00
OUTPATIENT SERVICE COST CENTERS		7,000				73.00
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	Ö				92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	1, 219	7, 008				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	1, 219	7, 008				202. 00

Heal th	Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10										
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150011	Peri od:	Worksheet D	2002 10				
7 1 0111	Tolument of The All Parts Parts Deliver of Children	2 000.0			From 07/01/2015	Part II					
			Component	CCN: 15T011	To 06/30/2016						
						11/23/2016 9:	25 am_				
			Ti tl	e XVIII	Subprovi der -	PPS					
		1			IRF						
	Cost Center Description	Capi tal	Total Charges			Capital Costs					
			(from Wkst. C,		Program	(column 3 x					
		(from Wkst. B,			. Charges	column 4)					
		Part II, col.	8)	2)							
		26)	0.00								
	ANOLILARY OF BUILDE OF SENTERS	1.00	2. 00	3. 00	4. 00	5. 00					
	ANCI LLARY SERVI CE COST CENTERS	1 040 700	100 000 700			700					
50. 00	05000 OPERATING ROOM	1, 949, 780			·	728					
51. 00	05100 RECOVERY ROOM	0		0.0000		0	51. 00				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 132, 902				1, 679					
57. 00	05700 CT SCAN	98, 164									
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	97, 144				l e					
59. 00	05900 CARDI AC CATHETERI ZATI ON	297, 721				137	59. 00				
60.00	06000 LABORATORY	782, 035				4, 268					
60. 01	06001 ONCOLOGY	40, 904	5, 857, 227			3	60. 01				
60. 02	06002 RADI ATI ON ONCOLOGY	0	0	0.00000	00	0	60. 02				
65.00	06500 RESPI RATORY THERAPY	293, 201			104, 313	3, 806	65. 00				
66.00	06600 PHYSI CAL THERAPY	113, 462	10, 197, 701	0. 01112	26 2, 505, 610	27, 877	66. 00				
69.00	06900 ELECTROCARDI OLOGY	419, 233	9, 679, 646	0. 04331	37, 784	1, 636	69. 00				
69. 01	06901 CARDI AC REHAB	72, 224	777, 186	0. 09293	30 0	0	69. 01				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	00	0	71. 00				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	00	0	72. 00				
73.00	07300 DRUGS CHARGED TO PATIENTS	347, 964	65, 267, 266	0.00533	413, 352	2, 204	73. 00				
	OUTPATIENT SERVICE COST CENTERS						1				
90.00	09000 CLI NI C	152, 089	629, 837	0. 24147	74 0	0	90.00				
91.00	09100 EMERGENCY	780, 099	66, 962, 768	0. 01165	52, 132	607	91. 00				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 385, 800	0. 00000	33, 579	0	92. 00				
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0			0	92. 01				
	OTHER REIMBURSABLE COST CENTERS						1				
95.00	09500 AMBULANCE SERVI CES						95. 00				
200.00		6, 576, 922	356, 507, 706		3, 367, 883	43, 353	200. 00				
		1 ., ,	1	1	1 .,						

Heal th	Financial Systems	MARION GENERA	AL HOS	PI TAL			In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	S	Provi der	CCN: 150011		riod: om 07/01/2015	Worksheet D Part IV	
	555.5			Component	CCN: 15T011	To 06/30/2016		Date/Time Pre 11/23/2016 9:	pared: 25 am
				Ti tl	e XVIII	S	ubprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursi	ng School	Allied Healt	th	All Other	Total Cost	
		Anesthetist					Medi cal	(sum of col 1	
		Cost				E	ducation Cost	through col. 4)	
		1. 00		2. 00	3.00		4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00		2.00	3.00		4.00	3.00	
50.00	05000 OPERATI NG ROOM	0		0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0		0		0	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0		0	0	0	54.00
57.00	05700 CT SCAN	0		0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0		0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0		0	0	0	59. 00
60.00	06000 LABORATORY	0		0		0	0	0	60.00
60. 01	06001 ONCOLOGY	0		0		0	0	0	60. 01
60. 02	06002 RADI ATI ON ONCOLOGY	0		0		0	0	0	60. 02
65.00	06500 RESPI RATORY THERAPY	0		0		O	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0		0		O	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0		0	0	0	69. 00
	06901 CARDI AC REHAB	0		0		0	0	0	69. 01
	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
00.00	OUTPATIENT SERVICE COST CENTERS		J		ı				00.00
90.00	09000 CLI NI C 09100 EMERGENCY	0		0		0	0	0	90.00
91.00		0		0		0	0	0	91.00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)			0		0	0	0	92. 00 92. 01
72. UT	OTHER REIMBURSABLE COST CENTERS		<u>'</u>	0		U	U	0	72.01
95 NN	09500 AMBULANCE SERVICES		T						95. 00
200.00		0		0		0	0	n	200. 00
_00.00	1.023. (11103-00-177)	1	1	O	ı	9	O ₁		1200.00

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS		Componen		From 07/01/2015 To 06/30/2016	Part IV	narodi
			Componen	L CCN. ISTOTI	10 00/30/2010	Date/Time Pre 11/23/2016 9:	pareu. 25 am
			Ti tl	e XVIII	Subprovi der -	PPS	20 4
					IRF		
	Cost Center Description	Total	Total Charges			I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.			Charges	
		col . 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4)	7.00		7)	10.00	
	ANOLLI ADV. CEDVI OF LOCK OFFITEDS	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		100 000 700	0.00000	0. 000000	27 /7/	
50.00		0	,			37, 676	
51.00	05100 RECOVERY ROOM	0	0 0 0 1 1 1			0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	26, 061, 161			38, 617	54.00
57. 00	05700 CT SCAN	0	30, 953, 528	1		60, 785	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 610, 520			7, 999	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	9, 069, 115			4, 165	
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY	0	13, 081, 643			71, 388 483	
60. 01	06002 RADI ATI ON ONCOLOGY	0	5, 857, 227			483	
	06500 RESPIRATORY THERAPY	0	8, 035, 526			104, 313	
66. 00	06600 PHYSI CAL THERAPY	0	10, 197, 701			2, 505, 610	
69. 00	06900 ELECTROCARDI OLOGY	0	9, 679, 646			2, 505, 610	1
69. 00	06901 CARDI AC REHAB	0	777, 186			37, 784	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	111, 100	0.00000		0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0.00000		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	65, 267, 266	1		413, 352	
73.00	OUTPATIENT SERVICE COST CENTERS	0	05, 207, 200	0.00000	0.000000	413, 332	73.00
90. 00	09000 CLINIC	0	629, 837	0.00000	0. 000000	0	90.00
91. 00	09100 EMERGENCY	0	66, 962, 768	1		52. 132	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 385, 800	1		33, 579	
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0,000,000	1		0.00,077	•
,	OTHER REIMBURSABLE COST CENTERS	<u> </u>	1	2. 23000	2. 223000		2.01
95. 00	09500 AMBULANCE SERVI CES						95. 00
200.00		0	356, 507, 706			3, 367, 883	
	,	1		1			

Heal th	Financial Systems	MARION GENERA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150011	Peri od:	Worksheet D	
THROUG	SH COSTS			0011 457044	From 07/01/2015		
			Component	CCN: 15T011	To 06/30/2016	Date/Time Pre 11/23/2016 9:	
-			Ti +I	e XVIII	Subprovi der -	PPS	25 alli
	Subprovider 115						
	Cost Center Description	I npati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
		Program	Program	Program	Physi ci an	Nursing School	
		Pass-Through	Charges	Pass-Through	n Anesthetist		
		Costs (col. 8		Costs (col.	9 Cost		
		x col. 10)		x col. 12)			
		11. 00	12.00	13. 00	21. 00	22. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60.01	06001 ONCOLOGY	0	0		0	0	60. 01
60.02	06002 RADI ATI ON ONCOLOGY	0	0		0 0	0	60. 02
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	o	0		0 0	0	69.00
69. 01	06901 CARDI AC REHAB	o	0		0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	ol	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	ol	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	o	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	92. 01
	OTHER REIMBURSABLE COST CENTERS	-1	-				1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0		0 0	0	200.00
		- 1		•		1	

Health Financial Systems	MARION GENERAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150011	Peri od: From 07/01/2015	Worksheet D
THROUGH COSTS		Component CCN: 15T011		
		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 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-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150011	Peri od: From 07/01/2015	Worksheet D-1	
				Date/Time Pre 11/23/2016 9:	pared: 25 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					

		Title XVIII	Hospi tal	PPS	
	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,			16, 592	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vato room dave	16, 592 0	2. 00 3. 00
3.00	do not complete this line.). IT you have only pir	vate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		13, 720	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
	reporting period				, 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	davs) through December	31 of the cost	0	7. 00
	reporting period	3 / 3			
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Dreamam (eveluding	cwing had and	6, 946	9. 00
9.00	newborn days)	the Program (excluding	Swirig-bed and	0, 940	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private ro	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		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		room days)	0	12.00
12.00	through December 31 of the cost reporting period	omy (mordaing private	, room days)	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar yea				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	iays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				,
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of t	ho cost	0.00	18. 00
18.00	reporting period	arter becember 31 or i	ne cost	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			18, 642, 809	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00
00.00	5 x line 17)	4 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	or the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		18, 642, 809	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	irges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 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	Average per diem private room charge differential (line 32 minu	, ,	ions)	0.00	34.00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost dif	ferential (line	18, 642, 809	37.00
	27 minus line 36)		, ,,,,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see i			1, 123. 60	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1			7, 804, 526	39.00
40. 00	Medically necessary private room cost applicable to the Program	,		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		7, 804, 526	41. 00

<u>Heal</u> th	Financial Systems	MARION GENERA	AL HOSPITAL		<u>In L</u> i e	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 07/01/2015	Worksheet D-1	
					To 06/30/2016	Date/Time Pre	
			T: +1	o V/////	Hooni tal	11/23/2016 9:	25 am
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	oust conton possification		Inpatient Days			(col. 3 x col.	
		1.00	0.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units			, 0.0	0 0		42.00
43.00	INTENSIVE CARE UNIT	6, 170, 877	4, 309	1, 432. 0	9 1, 919	2, 748, 181	43. 00
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00	Program inpatient ancillary service cost (Wk:	a+ D 2 and 2) Line 200)			1.00	40.00
48. 00 49. 00	Total Program inpatient costs (sum of lines			ons)		8, 561, 046 19, 113, 753	1
17.00	PASS THROUGH COST ADJUSTMENTS	ii tiii ougii 10) (300 111311 4011 6	, , , , , , , , , , , , , , , , , , ,		17, 110, 700	17.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	1, 384, 404	50. 00
51. 00		ationt ancillar	sy sorvicos (fr	com Wkst D si	um of Darte II	722, 123	51.00
51.00	and IV)	atrent ancirrai	y services (II	OIII WKSt. D, SI	um or raits ii	722, 123	31.00
52. 00	Total Program excludable cost (sum of lines					2, 106, 527	1
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anesth	etist, and	17, 007, 226	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55)	ing cost and to	wast smallet (1	ino E/ minuo l	lima E2)	0 0	
58.00	Difference between adjusted inpatient operations payment (see instructions)	ing cost and ta	irget amount (i	The so minus	i i ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and cor	mpounded by the		1
	market basket						/
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	1
01.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see instructions)						
	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						62.00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST						03.00
64.00		ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
45 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	or 21 of the c	act reporting	norial (Soc	0	65. 00
65. 00	instructions)(title XVIII only)	ts after becenik	ber 31 of the C	Lost reporting	perrou (see		05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only). For	0	66. 00
47.00	CAH (see instructions)		. D 21 -	.e			/7.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	i becember 31 c	or the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost repor	rting period	0	68. 00
	(line 13 x line 20)			(0)			/
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facility		•				70.00
71. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		. (lino 14 v li	no 25)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital -related cost allocated to inpatient	,			art II, column		75. 00
7/ 00	26, line 45)	2)					7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ lil Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minus	,					78. 00
79. 00	Aggregate charges to beneficiaries for excess				75		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		cost limitation	ı (IINe /8 mini	us line 79)		80.00
82. 00	Inpatient routine service cost per drein friin)				82.00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83. 00
84. 00	Program inpatient ancillary services (see in:		,,,,				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 55	PART IV - COMPUTATION OF OBSERVATION BED PASS		ugii 00)] 55. 55
87. 00	Total observation bed days (see instructions))				2, 872	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•				1, 123. 60 3, 226, 979	
07.00	lopser ration per cost (line of x line oo) (see	. 111311 4011 0115)] 3, 220, 7/9	J 07.00

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 07/01/2015 To 06/30/2016	Date/Time Prep 11/23/2016 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 619, 284	18, 642, 809	0. 14049	3, 226, 979	453, 384	90.00
91.00 Nursing School cost	0	18, 642, 809	0.00000	3, 226, 979	0	91.00
92.00 Allied health cost	0	18, 642, 809	0.00000	3, 226, 979	0	92.00
93.00 All other Medical Education	0	18, 642, 809	0. 000000	3, 226, 979	0	93. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150011		Worksheet D-1
	Component CCN: 15TO1	From 07/01/2015 To 06/30/2016	Date/Time Prepared: 11/23/2016 9:25 am
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 086	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed			3, 086	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days) do not complete this line.). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 086	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	
	reporting period	3 , 0			
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 of	Maye) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	days) till odgir becember	31 01 1110 0031	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	2, 518	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	/ (including private r	nom days)	0	10. 00
	through December 31 of the cost reporting period (see instruction	ons)	,	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	oom days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, enti-			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including privat	e room days)	0	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 year				
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 c	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	in ough becomber of or	110 0031	0.00	17.00
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			2 070 552	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	3, 878, 553 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost report	ring perrod (Trite	· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reportin	g period (line 6	0	23. 00
24.00	x line 18)	14 -E +L+	(1:	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	or the cost reporti	ng period (iine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	21 1: 2()		0	
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus iine 26)		3, 878, 553	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi-private room charges (excluding swing-bed charges)	>		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	ine 28)		0.000000	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	•
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x line	, ,	ŕ	0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	a private room cost di	TTERENTIAL (line	3, 878, 553	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 256. 82	
39. 00	Program general inpatient routine service cost (line 9 x line 3)			3, 164, 673	
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			0 3, 164, 673	40.00
- 1. 00	Trotal Trogram general impatrent routine service cost (Tille 37 +	11110 70)		5, 104, 075	71.00

Heal th	Financial Systems	MARION GENERAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	Fr	eriod: com 07/01/2015	Worksheet D-1	
			Component C			11/23/2016 9:	
			Title		Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient CostInp		Average Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4. 00 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	J O	٥	0.00	O _I	U	42.00
43.00	INTENSIVE CARE UNIT	0	0	0. 00	0	0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGI CAL INTENSI VE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					1, 150, 337	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see	instructions)		4, 315, 010	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine ser	vices (from W	kst. D, sum c	of Parts I and	453, 114	50.00
F1 00	[111]					42.252	F1 00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillary s	ervices (Trom	WKST. D, SUM	OT Parts II	43, 353	51. 00
52. 00	Total Program excludable cost (sum of lines	•				496, 467	•
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital relat 52)	ed, non-physi	cian anesthet	ist, and	3, 818, 543	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
	Difference between adjusted inpatient operat	ing cost and targe	t amount (lin	e 56 minus li	ne 53)	0	57. 00
58. 00	Bonus payment (see instructions)		. 4007			0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period end	ing 1996, upa	ated and comp	bounded by the	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	•
61. 00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target					0	61. 00
	amount (line 56), otherwise enter zero (see instructions)						
62. 00 63. 00							62. 00 63. 00
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstructi	uris)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decembe	r 31 of the c	ost reporting	period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cos	t reporting p	eriod (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino 64	nluc lino (E)	(+i +l o V)/	only) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Title 04	prus rine 03)	(title xviii	on y). To	O	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through De	cember 31 of	the cost repo	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Dece	mber 31 of th	e cost report	ing period	0	68. 00
40.00	(line 13 x line 20)	routing costs (lin	o (7 . lino (0)		0	69. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	•				0	09.00
	Skilled nursing facility/other nursing facil	ity/ICF/IID routin	e service cos				70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		70 ÷ 11ne 2)				71. 00 72. 00
	Medically necessary private room cost applic	•	ine 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 co	sts (from Wor	ksheet B, Par	t II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
	Program capital -related costs (line 9 x line						77. 00 78. 00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	•	ider records)				79.00
80.00	Total Program routine service costs for comp	arison to the cost		line 78 minus	Sline 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi						81. 00 82. 00
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
	Utilization review - physician compensation		ab OE)				85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		gii 85)				86. 00
87. 00	Total observation bed days (see instructions)				0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	ne 2)			0.00	88. 00 89. 00
37.00	(36)	ot. dot. ons)			I		, 57. 50

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	
		Component	CCN: 15T011	From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost 1.00	Routine Cost (from line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (2.00	
90.00 Capital -related cost	555, 317	3, 878, 553	0. 14317	6 0	0	90. 00
91.00 Nursing School cost	0	3, 878, 553			0	91. 00
92.00 Allied health cost	0	3, 878, 553			0	92.00
93.00 All other Medical Education	0	3, 878, 553	0. 00000	0 0	0	93. 00

Health Financial Systems	MARION GENERAL HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Peri od:	Worksheet D-1	
			From 07/01/2015		
			To 06/30/2016		
				11/23/2016 9:2	25 am
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days a	and swing-bed days,	excluding newborn)		16, 592	1. 00

	litie XIX Hospital	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16, 592	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	16, 592 0	2. 00 3. 00
3.00	In value from days, (excluding swing-bed and observation bed days). If you have only private room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13, 720	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period		0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	433	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private 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 only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	2, 045	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
40.00	reporting period		40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	18, 642, 809	21.00
22. 00	Swing-bed cost applicable to swritype services through becomber 31 of the cost reporting period (fine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	18, 642, 809	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	1
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	10 (42 000	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	18, 642, 809	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 123. 60	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	486, 519 0	39. 00 40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	486, 519	

30. 1	o penii -pi i vate i ooni charges (excruding swing-bed charges)	0	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 Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. (00 Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.	00 Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. (00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line	18, 642, 809	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. (00 Adjusted general inpatient routine service cost per diem (see instructions)	1, 123. 60	38. 00
39. (00 Program general inpatient routine service cost (line 9 x line 38)	486, 519	39.00
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)	486, 519	41.00

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 07/01/201 To 06/30/201		pared:
	Title XIX Hospital	11/23/2016 9: 2 Cost	25 am_
	Cost Center Description Total Total Average Per Program Days		
	Inpatient Cost Inpatient Days Diem (col. 1 ÷	(col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 2, 287, 535 2, 045 1, 118. 60	0 0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 6,170,877 4,309 1,432.09	0 0	43. 00
44. 00	CORONARY CARE UNIT		44. 00
45. 00 46. 00			45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
	Cost Center Description	1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	668, 559	•
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	d 0	50. 00
51. 00	III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	o	51. 00
	and IV)		
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	52. 00 53. 00
33. 00	medical education costs (line 49 minus line 52)		33.00
54 OO	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges		54. 00
55. 00			55. 00
56.00		0	56.00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the		59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	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	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64. 00		0	64. 00
65. 00	instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
65.00	instructions) (title XVIII only)		65.00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00		0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period		68. 00
00.00	(line 13 x line 20)		
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74.00	Total Program general inpatient routine service costs (line 72 + line 73) Conital related cost allocated to inpatient routine service costs (from Workshoot R. Part II., column		74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00 80. 00
80.00	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
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		83. 00 84. 00
85.00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00		2, 872	87. 00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 123. 60 3, 226, 979	
J 7. UU	Joseph Watter bod cost (This of A This bo) (See That well only	J, 220, 7/9	0 7. 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 07/01/2015		
				To 06/30/2016	Date/Time Prep	
		T' 1	1 1/11/			25 alli
			le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 619, 284	18, 642, 809	0. 14049	8 3, 226, 979	453, 384	90.00
91.00 Nursing School cost	0	18, 642, 809	0.00000	0 3, 226, 979	0	91.00
92.00 Allied health cost	0	18, 642, 809	0.00000	0 3, 226, 979	0	92.00
93.00 All other Medical Education	0	18, 642, 809	0.00000	0 3, 226, 979	0	93. 00

Health Financial Systems	MARION GENERAL HOSI	PI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	F			Worksheet D-1
	(Component CCN: 15TO11		
		Title XIX	Subprovi der -	Cost
			LDE	

Note			TI LIE XIX	IRF	COST	
Next Fact ALL PROVIDER COMPONENTS 1.00 1.		Cost Center Description			1.00	
NATLENT DAYS		PART I _ ALL PROVINER COMPONENTS			1.00	
1.00 Inpatient days (Including private room days, excluding swing-bed and network and by private room days, (a.d. a.d. a.d. a.d. a.d. a.d. a.d. a.d						
Private room days (excluding swing-bed and observation bed days). If you have only private room days 4.0					•	
do not complete this line. do				Lucto room doug		
Semi-private room days (excluding swing-bed and observation bed days) Semi-private room days (netuding private room days) after December 31 of the cost	3.00		i. II you have only pri	vate room days,	U	3.00
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x line 20) Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 878, 553) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 878, 553) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 878, 553) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 878, 553) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38)	25 00	,	of the cost reporting	period (line 8	0	25 00
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PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36.00 Private room cost differential adjustment (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 878, 553) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 3, 878, 553) 38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 3, 878, 553) 38.00 Average per diem charge (line 30 ÷ line 35) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 98.00 Program general inpatient routine service cost (line 9 x line 38) 0 Average per diem private room cost applicable to the Program (line 14 x line 35) 0 Average per diem private room cost applicable to the Program (line 14 x line 35)			04 ' '' 04'			
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 878, 553) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 36) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 36) 30.00 Average per diem private room cost differential (line 3 x line 36) 30.00 Average per diem private room cost differential (line 3 x line 36) 30.00 Average per diem private room cost differential (line 3 x line 36) 30.00 Average per diem private room cost differential (line 3 x line 36)	27.00		ne 21 minus iine 26)		3, 878, 553	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 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, 878, 553) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 20.00 30.00	28. 00		and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 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, 878, 553) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 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	29. 00	Private room charges (excluding swing-bed charges)				
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Average per diem private room cost differential (line 3 x line 35) 35.00 Average per diem private room cost differential (line 3 x line 35) 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, 878, 553) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 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			ino 20)			
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, 878, 553) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 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, 878, 553) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 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, 878, 553 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 0 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			, ,	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 878, 553 27.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 256.82 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 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, 256. 82 38.00 Program general inpatient routine service cost (line 9 x line 38) 0 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, 256.82 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	200	27 minus line 36)	,			
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 256.82 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 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) 0 39.00 40.00	38 NN			T	1 256 92	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 0 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		0	41. 00

Heal th	Financial Systems	MARION GENERAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	Fr	eriod: rom 07/01/2015	Worksheet D-1	
			Component C			11/23/2016 9:	
			Title	XIX	Subprovider - IRF	Cost	
	Cost Center Description	Total Inpatient CostInp		Average Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCERV (+; +l - V 0 VIV and a)	1.00	2.00	3. 00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42.00
	INTENSIVE CARE UNIT	0	0	0. 00	0	0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGI CAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					0	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(See	Instructions	5)		0	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine ser	vices (from W	/kst. D, sum o	of Parts I and	0	50. 00
51. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillary s	ervices (from	n Wkst. D, sun	of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital relat	ed, non-physi	cian anesthet	ist, and	0	1
	medical education costs (line 49 minus line	52)					_
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	1
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targe	et amount (lin	ne 56 minus li	ne 53)	0	
	Bonus payment (see instructions)	ing cost and targe	t amount (iiii	10 00 11111103 11	110 00)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period end	ing 1996, upd	lated and comp	oounded by the	0. 00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, updat	ed by the mar	ket basket		0.00	60.00
61. 00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61. 00
	amount (line 56), otherwise enter zero (see		1111eS 54 X 60	7), 01 1% 01 1	.ne target		
62.00	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						62.00
03.00	PROGRAM I NPATIENT ROUTINE SWING BED COST						63.00
64. 00	64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cos	t reporting p	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 64	plus line 65)	(title XVIII	only). For	0	66. 00
	CAH (see instructions)					2	
67.00	67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13×1 line 20)	e costs after Dece	mber 31 of th	e cost report	ing period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	•				0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
	Adjusted general inpatient routine service c						71.00
	Program routine service cost (line 9 x line		ino 14 y lino) 2E)			72.00
73.00	Medically necessary private room cost applic Total Program general inpatient routine serv			: 35)			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient	routine service co	sts (from Wor	ksheet B, Par	t II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ider records)				78. 00 79. 00
	Total Program routine service costs for comp				s line 79)		80.00
	Inpatient routine service cost per diem limi		·				81.00
	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
	Utilization review - physician compensation						85. 00 86. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		gii oo <i>)</i>				00.00
87.00	Total observation bed days (see instructions)	no 2)			0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	He ∠)			0.00	88. 00 89. 00
		,			'		•

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T011	From 07/01/2015 To 06/30/2016		
		Tit	le XIX	Subprovi der - I RF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	555, 317	3, 878, 553	0. 14317	6 0	0	90. 00
91.00 Nursing School cost	0	3, 878, 553	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 878, 553	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 878, 553	0. 00000	o o	0	93. 00

	Financial Systems	MARION GENERAL HOSPITAL	CON 150011		u of Form CMS-:	
INPAILI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150011	Peri od: From 07/01/2015	Worksheet D-3	
				To 06/30/2016	Date/Time Pre 11/23/2016 9:	pared:
		Ti tl	e XVIII	Hospi tal	PPS	25 4111
	Cost Center Description		Ratio of Cos		Inpati ent	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	INDATIENT DOUTINE CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			8, 170, 103		30.00
	03100 INTENSIVE CARE UNIT			4, 246, 188		31.00
	04000 SUBPROVI DER - I PF			4, 240, 100		40.00
	04100 SUBPROVI DER - I RF			0		41.00
	04200 SUBPROVI DER			0		42.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 1960		2, 823, 371	
	05100 RECOVERY ROOM		0.0000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 3513		329, 891	
	05700 CT SCAN		0. 0463	· ·	118, 249	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 2331 0. 3894		44, 928 429, 216	
	06000 LABORATORY		0. 3894		1, 266, 800	
	06001 ONCOLOGY		0. 4095		8, 981	
	06002 RADIATION ONCOLOGY		0.0000		0, 701	1
	06500 RESPIRATORY THERAPY		0. 4617		698, 974	
	06600 PHYSI CAL THERAPY		0. 3565		693, 531	
69. 00	06900 ELECTROCARDI OLOGY		0. 2442	46 1, 993, 395	486, 879	69.00
69. 01	06901 CARDI AC REHAB		0. 5894	21 0	0	69. 0°
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 2044	88 3, 768, 830	770, 681	73.00
	OUTPATIENT SERVICE COST CENTERS		1 (0/4	1/	0	00.00
	09000 CLI NI C 09100 EMERGENCY		1. 6064 0. 1526		0 709, 638	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1526		179, 907	
	09201 OBSERVATION BEDS (NON-DISTINCT FART)		0.0000	· ·	0	
	OTHER REIMBURSABLE COST CENTERS		3. 5000	<u> </u>		1 /2.0
	09500 AMBULANCE SERVI CES					95.00
200. 00				34, 896, 194	8, 561, 046	200.00
201.00	Less PBP Clinic Laboratory Services-Progr	ram only charges (line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			34, 896, 194		202. 00

Health Financial Systems	MARION GENERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150011	Peri od:	Worksheet D-3	
	Component	t CCN: 15T011	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/23/2016 9:	
	Ti tI	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER - PF			ő		40.00
41. 00 04100 SUBPROVI DER - I RF			3, 282, 432		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1960			
51. 00 05100 RECOVERY ROOM		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3513 0. 0463		13, 567	
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 0463			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3894	91 4, 165		
60. 00 06000 LABORATORY		0. 8339			
60. 01 06001 0NCOLOGY		0. 4095			1
60. 02 06002 RADIATION ONCOLOGY		0. 0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 4617		48, 164	
66. 00 06600 PHYSI CAL THERAPY		0. 3565	41 2, 505, 610	893, 353	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2442		9, 229	69.00
69. 01 06901 CARDI AC REHAB		0. 5894	21 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2044	88 413, 352	84, 526	73. 00
OUTPATIENT SERVICE COST CENTERS		1 (0/4	4./	1 0	
90. 00 09000 CLI NI C		1. 6064		_	
91. 00 09100 EMERGENCY		0. 1526			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 5991 0. 0000			
OTHER REIMBURSABLE COST CENTERS		0.0000	00	1	72.01
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50-94 and 96-98)			3, 367, 883	1, 150, 337	
201.00 Less PBP Clinic Laboratory Services-Prod	gram only charges (line 61)		0	1, 122, 00,	201. 00
202.00 Net Charges (line 200 minus line 201)	5 5 2 5 5 2 7		3, 367, 883		202. 00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Pre 11/23/2016 9:	pare
	Ti t	le XIX	Hospi tal	Cost	20 ai
Cost Center Description	,	Ratio of Cos To Charges	st Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			514, 603		30.
. 00 03100 INTENSIVE CARE UNIT			115, 746		31.
0. 00 04000 SUBPROVI DER - 1 PF			0		40.
I. 00 04100 SUBPROVI DER - I RF			0		41.
2. 00 04200 SUBPROVI DER 3. 00 04300 NURSERY			0		42. 43.
ANCI LLARY SERVI CE COST CENTERS			0		J 43.
0. 00 05000 OPERATI NG ROOM		0. 1960	80 339, 360	66, 542	50.
. 00 05100 RECOVERY ROOM		0.0000		0	51.
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3513	14 15, 556	5, 465	54.
7.00 05700 CT SCAN		0. 0463	57 35, 591	1, 650	57.
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2331		153	
P. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3894		5, 732	
0. 00 06000 LABORATORY		0. 8339	•		
0. 01 06001 0NCOLOGY		0. 4095		0	
0. 02 06002 RADI ATI ON ONCOLOGY		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY 5. 00 06600 PHYSI CAL THERAPY		0. 4617	· ·		1
2. 00 06900 ELECTROCARDI OLOGY		0. 3565 0. 2442	· ·	3, 940 5, 993	
2. 01 06901 CARDI AC REHAB		0. 5894		0, 773	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2044		19, 513	
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C		1. 6064	16 0	0	90.
. 00 09100 EMERGENCY		0. 1526		17, 423	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5991		0	
2. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	00 0	0	92
OTHER REIMBURSABLE COST CENTERS OO O9500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50-94 and 96-98)			737, 481	182, 040	
10.00 Less PBP Clinic Laboratory Services-Program	only charges (line 61)		/3/, 481	102, 040	200
Net Charges (line 200 minus line 201)	only charges (Title 61)		737, 481		201

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 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/23/2016 9:25 am

			10 00/30/2010	11/23/2016 9:	
		Title XVIII	Hospi tal	PPS	
	DART A ANDATIENT HOODITAL OFFICE CONTROL AND			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	g prior to October 1 (see	0 3, 635, 031	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	g on or after October	1 (see	11, 667, 924	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	di scharges occurri ng	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			71, 453 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction		0	2. 02	
3.00	Managed Care Simulated Payments	113)		0	3.00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	ing period (see instru	ctions)	89. 15	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet th for new programs in accordance with 42 CFR 413.79(e)	0. 00	6. 00		
7.00	MMA Section 422 reduction amount to the IME cap as specified un	der 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified ulf the cost report straddles July 1, 2011 then see instructions)(1)(iv)(B)(2)	0.00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79 1998), and 67 FR 50069 (August 1, 2002).	0. 00	8. 00		
8. 01	The amount of increase if the hospital was awarded FTE cap slot the cost report straddles July 1, 2011, see instructions.	0. 00	8. 01		
8. 02	The amount of increase if the hospital was awarded FTE cap slot under section 5506 of ACA. (see instructions)	0. 00	8. 02		
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	0. 00	9. 00		
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the currer FTE count for residents in dental and podiatric programs.	it year from your recor	ds	0. 00 0. 00	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)				12.00
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	tember 30, 1997,	0.00	14. 00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital closu	ire		0.00	17. 00
18.00	Adjusted rolling average FTE count			0.00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section	n 422 of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resider $(f)(1)(iv)(C)$.		ec. 412.105	0.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the loinstructions)	wer of line 23 or line	24 (see	0.00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28.00	IME add-on adjustment amount (see instructions)				28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)				28. 01
29.00	Total IME payment (sum of lines 22 and 28)				29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		0	29. 01	
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruc	tions)	7. 05	30.00
31.00	Percentage of Medicaid patient days (see instructions)	•	25. 12	1	
32.00	Sum of lines 30 and 31			32. 17	1
33. 00	Allowable disproportionate share percentage (see instructions)			15. 75	
34. 00	Disproportionate share adjustment (see instructions)			602, 554	34. 00

	Financial Systems MARION GENERAL H ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Pre 11/23/2016 9:	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
5. 00	Total uncompensated care amount (see instructions)		7, 647, 644, 885	6, 406, 145, 534	35. 00
5. 01	Factor 3 (see instructions)		0. 000147542	0. 000148874	
5. 02		zero on this line)	1, 128, 349	953, 711	35. 02
E 02	(see instructions)	at (see instructions)	204 404	713, 980	35. 03
5. 03 6. 00	Pro rata share of the hospital uncompensated care payment amour Total uncompensated care (sum of columns 1 and 2 on line 35.03)		284, 406 998, 386	713, 960	36.00
0.00	Additional payment for high percentage of ESRD beneficiary disc				00.00
0.00	Total Medicare discharges on Worksheet S-3, Part I excluding di	scharges for MS-DRGs	0		40. 00
1 00	652, 682, 683, 684 and 685 (see instructions)		0		41 00
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683 instructions)		41.00		
1. 01	, and the second				
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qualify Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,		0.00		42. 00 43. 00
3.00	linstructions)	003, 004 all 003. (See	0		43.00
4. 00	Ratio of average length of stay to one week (line 43 divided by	y line 41 divided by 7	0. 000000		44.00
	days)				
5. 00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.0	11)	0.00		45. 00 46. 00
7. 00	Subtotal (see instructions)	51)	16, 975, 348		47.00
8. 00	Hospital specific payments (to be completed by SCH and MDH, small	all rural hospitals	16, 856, 610		48. 00
	only. (see instructions)				
				Amount 1.00	
9. 00	Total payment for inpatient operating costs (see instructions)			16, 975, 348	49. 00
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	Pt. II, as applicable)		1, 244, 441	50.00
1.00	Exception payment for inpatient program capital (Wkst. L, Pt. I			0	51.00
2.00	Direct graduate medical education payment (from Wkst. E-4, line Nursing and Allied Health Managed Care payment	e 49 see instructions).		0	52. 00 53. 00
4. 00	Special add-on payments for new technologies			0	54.00
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69))		0	55. 00
6. 00	Cost of physicians' services in a teaching hospital (see intrud	•		0	56. 00
7.00	Routine service other pass through costs (from Wkst. D. Pt. III		hrough 35).	0	57.00
8. 00 9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IN Total (sum of amounts on lines 49 through 58)	7, COL. 11 TIME 200)		0 18, 219, 789	
0.00	Primary payer payments			3, 461	1
1. 00	Total amount payable for program beneficiaries (line 59 minus I	ine 60)		18, 216, 328	61.00
2. 00	Deductibles billed to program beneficiaries			2, 076, 844	
3.00	Coinsurance billed to program beneficiaries			19, 138	
4.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			144, 961 94, 225	
6. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		52, 886	
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		16, 214, 571	67. 00
8. 00	Credits received from manufacturers for replaced devices for a			0	
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F	For SCH see instruction	s)	0	l l
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT			0	70.00
0. 88	SCH or MDH volume decrease adjustment			0	70. 88
0. 89	Pioneer ACO demonstration payment adjustment amount (see instru	uctions)		0	70. 89
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
0. 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	
0. 92	HVBP payment adjustment amount (see instructions)			47, 231	
	HRR adjustment amount (see instructions)			0	1
0. 94					

	Financial Systems MARION GENERAL HO				u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150011	Peri od:	Worksheet E	
				From 07/01/2015 To 06/30/2016	Part A Date/Time Pre	narod:
				10 00/30/2010	11/23/2016 9:	25 am
		Ti tl	e XVIII	Hospi tal	PPS	
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
	the corresponding federal year for the period ending on or afte	r 10/1)				
70. 98	Low Volume Payment-3				0	, 0. , 0
70. 99	HAC adjustment amount (see instructions)				126, 251	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			16, 135, 551	
71. 01	Sequestration adjustment (see instructions)			322, 711		
	Interim payments			16, 332, 354		
73.00	Tentative settlement (for contractor use only)				0	
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72,				-519, 514	
75. 00	Protested amounts (nonallowable cost report items) in accordance	e with			370, 173	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instr	uctions)			0	
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	
92.00	Operating outlier reconciliation adjustment amount (see instruc				0	92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instructi				0	93. 00
94. 00	The rate used to calculate the time value of money (see instruc	tions)			0. 00	
	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instructi	ons)			0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount				_	
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			T		
	HVBP adjustment factor (see instructions)			0. 0000000000		
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					ļ
	HRR adjustment factor (see instructions)			0. 0000	0.0000	
104 00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104.00

CALCUL	ALCULATION OF DSH PAYMENT PERCENTAGE				Period: From 07/01/2015	Worksheet DSH	
					To 06/30/2016	Date/Time Pre	pared:
-			Title	e XVIII	Hospi tal	11/23/2016 9: 2 PPS	25 am
		Original .mcrxAdj	usted .mcax		Overri de Value		
		Val ues 1.00	Val ues 2. 00	3. 00	4. 00	5. 00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE	1.00	2.00	3.00	4.00	3.00	
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line	7. 05	0.00	0.00	0.00	0. 00	1. 00
2.00	30 - Revised from CMS) Percentage of Medicaid patient days to total days (From line 27)	25. 12	0. 00			25. 12	2. 00
3. 00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	32. 17	0. 00			25. 12	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,	89. 15	0. 00			89. 15	5. 00
6. 00	Part A, Line 4) Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	15. 75	0. 00			9. 94	6. 00
7. 00	Oualify 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	Yes No				Yes No	8. 00 9. 00
	with 100 or more beds)?						10.00
10. 00 11. 00	S-2, Line 45 Is the provider reimbursed under the fully	No Yes				No Yes	11. 00
10.00	prospective method? (Worksheet L, Part I, line 1 geater than -0-)		0.00	0.00		0.00	40.00
12. 00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0. 00	0. 00	0.00	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	Yes				Yes	13. 00
14. 00	75, column 1 = "Y") Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1. 83	0. 00	0. 00	0.00	0. 00	14. 00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAY						
15. 00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	433	0			433	15.00
16. 00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1, 841	0			1, 841	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, 808	0 0			0 2, 808	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	5, 082	0			5, 082	21. 00
22. 00	calculation (sum of lines 15-20) Total patient days (Worksheet S-3, Part I,	20, 074	0			20, 074	22. 00
23. 00	Column 8, Line 14) Plus total labor room days (Worksheet S-3,	o	0			0	23. 00
24. 00	Part I, Column 8, Line 32) Plus total employee discount days (Worksheet	160	0			160	24. 00
25. 00	S-3, Part I, Column 8, Line 30) Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	o	0			0	25. 00
26. 00	and 6) Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line	20, 234	O			20, 234	26. 00
27. 00	25) Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	25. 12	0. 00			25. 12	27. 00

Health Financial Systems	MARION GENER	AL HOSPI	I TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Pr	rovi der		Peri od:	Worksheet DSH	
					From 07/01/2015 To 06/30/2016		
			Title	e XVIII	Hospi tal	PPS	
	Ori gi nal . ı	mcrx Val	ues	Adj usted	mcax Values	Revi sed	
	Condi ti on	Percei	entage	Condi ti on	Percentage	Condi ti on	
	1. 00	2. (00	3. 00	4. 00	5. 00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAG	E						
28.00 If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and	True		15. 76		0.00	True	28. 00
line 3							
29.00 If line 3 is less than 20.2% - 2.5% plus 65%	Fal se		0. 00		0.00	Fal se	29. 00
of the difference between 15% and line 3			45 7/				
30.00 Line 28 or 29 as applicable		1	15. 76		0.00		30.00
31.00 If Urban and fewer than 100 beds, Rural and			15. 76		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	Adjuste	ed .mcax	HFS Look Up	Overri de Val ue	Revi sed Value	
	Val ues	Valu	ues	·			
	1. 00	2.0	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	1				True	33 00

True

Fal se

True

Rural

33.00 Is This a Rural Referral Center? (Worksheet S-2, Part I, Line 116, column 1 = "Y")
34.00 Is this a Medicare Dependant Hospital?

36.00 Is this an Urban or Rural hospital?

-0-)

-0-)

35.00

(Worksheet S-2, Part I, Line 37 greater than

Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than

(Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)

True

Fal se

True

Rural

33.00

34.00

35.00

Health Financial Systems	HOSPITAL In Lieu of Form CMS-2				
CALCULATION OF DSH PAYMENT PERCENTAGE		Provi der CCN: 150011	Peri od: From 07/01/2015	Worksheet DSH	
				Date/Time Prep 11/23/2016 9:2	
		Title XVIII	Hospi tal	PPS	
	Revi sed				

			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	9. 94				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	9. 94				30.00
31.00	If Urban and fewer than 100 beds, Rural and	9. 94				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 Provider CCN: 150011

					'	0 06/30/2016	11/23/2016 9:	
	,				e XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	C		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	3, 635, 031	0	3, 635, 031		3, 635, 031	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	11, 667, 924	0		11, 667, 924	11, 667, 924	1. 02
1. 02	payments for discharges occurring on or after October	1. 02	11, 667, 721	S		11,007,721	11,007,721	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	71, 453	0	29, 294	42, 159	71, 453	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	C	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0	С	0	0	4. 00
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	C	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see instructions)							
7. 00	Indirect Medical Education Adju	ustment for the	0.000000	0.000000	ne MMA 0.000000	0. 000000		 7.00
7.00	(see instructions)	27.00	0.00000	0.000000	0.000000	0.000000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	O	0	C	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	0	0	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1575	0. 1575	0. 1575	0. 1575		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	602, 554	0	143, 129	459, 425	602, 554	11. 00
11. 01	Uncompensated care payments	36. 00	998, 386	0	284, 406	713, 980	998, 386	11. 01
10.00	Additional payment for high per		RD beneficiary				^	12.00
12.00	Total ESRD additional payment (see instructions)	46. 00	0	0	4 001 076		0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	16, 975, 348 16, 856, 610	0	4, 091, 860 4, 214, 153		16, 975, 348 16, 856, 610	
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	16, 975, 348	0	4, 091, 860	12, 883, 488	16, 975, 348	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	1, 244, 441	0	297, 106	947, 335	1, 244, 441	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	С	О	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	55. 00 68. 00	0	0	C	_	0	1
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0	C		0	
	adjustment amount (see instructions)							

	LOWE CALCULATION EXHIBIT 4					From 07/01/2015 To 06/30/2016	11/23/2016 9:	pared:
					e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	T	0	1. 00	2. 00	3.00	4. 00	5. 00	
19. 00	SUBTOTAL			0	4, 388, 96	6 13, 830, 823	18, 219, 789	19.00
		W/S L, line	(Amounts from					
		_	L)					
	I	0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier		1, 225, 274	0	290, 49	7 934, 777	1, 225, 274	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0	0	20. 01
	than outlier			_				
21. 00	Capital DRG outlier payments	2. 00	19, 167	0	6, 60	9 12, 558	19, 167	
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0.000	0.0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	0		0	0	23. 00
	adjustment (see instructions)							
24. 00	Allowable disproportionate	10. 00	0. 0000	0. 0000	0.000	0.0000		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0		0	0	25. 00
	adjustment (see instructions)			_				
26. 00	Total prospective capital	12. 00	1, 244, 441	0	297, 10	6 947, 335	1, 244, 441	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)	0.00	2 22	4.00	F 00	
07.00	I	0	1. 00	2. 00	3.00	4. 00	5. 00	07.00
27. 00	Low volume adjustment factor	70.07			0. 00000	0. 000000		27. 00
28. 00	Low volume adjustment	70. 96				O	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)	70.07						
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
100.00	Pt. A, line)		V					100.00
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.				l			I

HU3P1 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	rom 07/01/2015 o 06/30/2016	Date/Time Pre 11/23/2016 9:	pared:			
			Title	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2.00	0.00	1. 00	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	3, 635, 031	3, 635, 031		3, 635, 031	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	11, 667, 924		11, 667, 924	11, 667, 924	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00	71, 453	29, 294	42, 159	71, 453	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0 0	0 0		3. 00 4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	0	0	1	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0		
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	"	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29. 01	0	0	0	0	9. 01
10.00	Allowable disproportionate share percentage	33.00	0. 1575	0. 1575	0. 1575		10. 00
	(see instructions)						
11. 00	Disproportionate share adjustment (see instructions)	34.00	602, 554	143, 129	459, 425	602, 554	11. 00
11. 01	Uncompensated care payments	36.00	998, 386	284, 406	713, 980	998, 386	11. 01
	Additional payment for high percentage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12. 00
13.00	Subtotal (see instructions)	47.00	16, 975, 348	4, 091, 860	12, 883, 488	16, 975, 348	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	16, 856, 610	4, 214, 153	12, 642, 457	16, 856, 610	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	16, 975, 348	4, 091, 860	12, 883, 488	16, 975, 348	15. 00
16. 00	Payment for inpatient program capital	50. 00	1, 244, 441	1, 541, 547	-297, 106	1, 244, 441	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	17. 00
17. 01	Net organ aquisition cost	55. 00	l ol	0	0	Ö	
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	O	0	0	o o	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			5, 633, 407	12, 586, 382	18, 219, 789	19. 00

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPITAL ACQUIRED CONDITION (HAC)	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibi Date/Time Prep 11/23/2016 9:2	pared:	
		Ti tl	e XVIII	Hospi tal	PPS		
	Wkst. L, line	(Amt. from					

					To 06/30/2016	Date/Time Pre 11/23/2016 9:	pared: 25 am
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	1, 225, 274	1, 515, 77	1 -290, 497	1, 225, 274	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	19, 167	25, 77	6 -6, 609	19, 167	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0		0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 244, 441	1, 541, 54	7 -297, 106	1, 244, 441	26. 00
	[THSTFuctions)	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		A, TITIE	A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00			1.00	2.00	0.00	1.00	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		n	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	o o	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	47, 231	8, 47	6 38, 755		30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 75	1 47, 231	0, 47	0 30, 733	47, 231	30. 01
30.01	payment (see instructions)	70. 70				ĺ	30.01
31. 00	HRR adjustment (see instructions)	70. 94	0		0	0	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0			o o	31. 01
01.01	instructions)	70.71					01.01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0 126, 251	126, 251	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Υ				100. 00
	moe: 2/ / c: / ii	1	ı	ı	1	ı	'

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	From 07/01/2015	Worksheet E Part B Date/Time Pre 11/23/2016 9::	
	Title XVIII	Hospi tal	PPS	

		10 00/30/2010	11/23/2016 9:	
		Title XVIII Hospital	PPS	20 4111
		11 (1 0 7/11)	1	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		8, 227	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)	20, 152, 778	2. 00
3.00	PPS payments	•	17, 250, 483	3. 00
4.00	Outlier payment (see instructions)		181, 375	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	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200	0	9. 00
10.00	Organ acqui si ti ons		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		8, 227	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12. 00	Ancillary service charges		35, 731	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)	0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)		35, 731	14. 00
	Customary charges		_	
15. 00	Aggregate amount actually collected from patients liable for pa		0	
16. 00	Amounts that would have been realized from patients liable for	payment for services on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)		0.000000	17 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	
18.00	Total customary charges (see instructions)	if line 10 avecade line 11) (acc	35, 731	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	IT Time 18 exceeds Time II) (See	27, 504	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 eveneds line 10) (see	0	20. 00
20.00	instructions)	IT TITLE IT exceeds TITLE To) (See		20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)	8, 227	21. 00
22. 00	Interns and residents (see instructions)	Thistractions)	0,227	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ot. 0.10)	17, 431, 858	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		117 1017 000	
25. 00	Deductibles and coinsurance (for CAH, see instructions)		0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)	3, 599, 592	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		13, 840, 493	
	instructions)	- (
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)		13, 840, 493	30. 00
31.00	Primary payer payments		3, 926	31. 00
32.00	Subtotal (line 30 minus line 31)		13, 836, 567	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	5)		
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)		0	
34. 00	Allowable bad debts (see instructions)		988, 037	
35. 00	Adjusted reimbursable bad debts (see instructions)		642, 224	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	644, 017	
37. 00	Subtotal (see instructions)		14, 478, 791	
38. 00	MSP-LCC reconciliation amount from PS&R		-186	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
39. 50	Prioneer ACO demonstration payment adjustment (see instructions)	d dayi ass (see i notrusti ans)	0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40.00	Subtotal (see instructions)		14, 478, 977	40.00
40. 01	Sequestration adjustment (see instructions)		289, 580	
41.00	Interim payments		14, 129, 344	
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)		60, 053	
44. 00	Protested amounts (nonallowable cost report items) in accordance	a with CMS Dub 15.2 chapter 1	00,033	1
44.00	§115. 2	e with CM3 Fub. 15-2, Chapter 1,		44.00
	TO BE COMPLETED BY CONTRACTOR		I	
90.00	Original outlier amount (see instructions)		0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	
92. 00	The rate used to calculate the Time Value of Money		0.00	
93. 00	Time Value of Money (see instructions)		0.00	
	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

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

					11/23/2016 9: 2	25 am
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		16, 249, 39	9	13, 553, 923	1. 00
2.00	Interim payments payable on individual bills, either			0	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)					
	Program to Provider			5 04 400 4004 4	1/0 001	
3. 01	ADJUSTMENTS TO PROVIDER	06/30/2016	82, 95		468, 321	3. 01
3. 02				0 06/30/2016	107, 100	3. 02
3. 03			1	0	0	3. 03
3.04				0	0	3. 04
3. 05	Dravi dan ta Dragnam			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		1	ol	0	3. 50
3. 51	ADJUSTIMENTS TO FROGRAM			0		3. 50
3. 52				0		3. 51
3. 53			1	0		3. 53
3. 54			1	0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		82, 95	~	575, 421	3. 99
0. 77	3. 50-3. 98)		02, 70		0,0,121	0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		16, 332, 35	4	14, 129, 344	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T	T	al		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02 5. 03
5. 03	Dravidor to Dragram			U	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			ol	1 0	5. 50
5. 51	I LIVIATI VE TO TROURAW		1	0		5. 50
5. 52			1	o		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
J. , ,	5. 50-5. 98)			-		5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					2.00
6. 01	SETTLEMENT TO PROVIDER			О	60, 053	6. 01
6. 02	SETTLEMENT TO PROGRAM		519, 51	4	0	6. 02
7. 00	Total Medicare program liability (see instructions)		15, 812, 84		14, 189, 397	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8.00	Name of Contractor	I				8. 00

Health Financial Systems MARANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Inpatient Part A			Ti tl	e XVIII	Subprovi der - I RF	PPS	
1.00 Total InterIm payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A	Par	t B	
1.00 Total interim payments paid to provider 3,956,378 0 1.00 0 2.00 0 0 0 0 0 0 0 0 0			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00			4. 00	
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			0		0	2. 00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER DO 0 0 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO PROGRAM DO 0 0 3.50 Provider to Program ADJUSTMENTS TO PROGRAM DO 0 0 3.55 3.50 DO 0 0 3.55 3.51 DO 0 0 3.55 3.53 DO 0 0 3.55 3.54 DO 0 0 0 3.55 3.55 DO 0 0 0 3.55 3.56 DO 0 0 3.55 3.57 DO 0 0 0 3.55 3.59 DO 0 0 0 3.55 3.50 DO 0 0 0 3.55 DO 0 0 0 3.55 DO 0 0 0 0 3.55 DO 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
3.02 3.02 3.03 3.04 3.05 3.03 3.04 3.05 3.03 3.04 3.05				1			
3.03 0	3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 04 0	3.02			0		0	3.02
3.05	3.03			0		0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50							
3.50 ADJUSTMENTS TO PROGRAM	3.05			0		0	3. 05
3.51 0				Г	T		
3.52 3.53 3.53 3.53 3.53 3.53 3.53 3.53 3.50		ADJUSIMENTS TO PROGRAM					
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.54 3.99 3.50-3.98) 3.956,378 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98) 3.99 3.996,378 0 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 3.956,378 0 4.00 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 3.956,378 0 4.00 4				· ·			
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 O1-3 49 minus sum of lines		· ·			
A. 00 Total interim payments (sum of lines 1, 2, and 3.99) 3,956,378 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	0. 77					Ĭ	0. 77
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			3, 956, 378		o	4.00
TO BE COMPLETED BY CONTRACTOR Solution		(transfer to Wkst. E or Wkst. E-3, line and column as					
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					1		
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER							
5. 02	5 01			0			5 01
Description		TENTATI VE TO TROVIDER					
Provider to Program						- 1	
TENTATI VE TO PROGRAM 0		Provider to Program		_	II.	_	
5. 52 0 0 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 0 0 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 0 0 5. 99 6. 00 Determined net settlement amount (balance due) based on	5.50			0		0	5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) O 1. 00 2. 00	5.51			0		0	5. 51
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	5.52			0		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00							,
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 15,072 3,941,306 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			_			6 01
7.00 Total Medicare program liability (see instructions) 3,941,306 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				15 072			
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total mode od o program trabitity (see thistractions)		3, 711, 300			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

MADION OFNEDAL HOODITAL						
	Financial Systems MARION GENERAL HO ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150011	Period:	u of Form CMS-2 Worksheet E-1	2552-10	
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN. 150011	From 07/01/2015			
			To 06/30/2016	Date/Time Pre		
				11/23/2016 9:	25 am_	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			5 100		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S		14	5, 198	1.00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	2		8, 865	2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0		2, 187	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		18, 029	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	0.0		393, 477, 980	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin			8, 835, 152	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cer line 168	TITIED HII TECHNOLOGY	WKST. S-2, PT. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			881. 013	8. 00	
9. 00	Sequestration adjustment amount (see instructions)			17, 620	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		863, 393		
10.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	111311 4011 6113)		000, 070	10.00	
30. 00	Initial/interim HIT payment adjustment (see instructions)			932, 678	30. 00	
	Other Adjustment (specify)			0	31. 00	
	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	s)	-69, 285		
	, , , , , , , , , , , , , , , , , , , ,	, (, , , , , , , , , , , , , , , , , ,	- / .	Overri des		
				1. 00		
	CONTRACTOR OVERRIDES					
108.00	Override of HIT payment			0	108. 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 07/01/2015	Worksheet E-3
	Component CCN: 15TO11		
	Title XVIII	Subprovi der -	PPS
		I RF	

	IRF		
		1.00	
	DADT LLL MEDICADE DADT A SERVICES LDE DDS	1. 00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	3, 889, 276	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0183	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	96, 843	3. 00
4. 00	Outlier Payments	87, 849	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
0.00	to November 15, 2004 (see instructions)	0.00	0.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	8. 431694	
11.00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00 13. 00	Teaching Adjustment (see instructions)	0	12. 00 13. 00
14. 00	Total PPS Payment (see instructions) Nursing and Allied Health Managed Care payments (see instruction)	4, 073, 968 0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	١	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17. 00	Subtotal (see instructions)	4, 073, 968	
18. 00	Primary payer payments	4, 073, 308	18. 00
19. 00	Subtotal (line 17 less line 18).	4, 073, 968	
20. 00	Deducti bl es	38, 052	
21. 00	Subtotal (line 19 minus line 20)	4, 035, 916	
22. 00	Coi nsurance	14, 175	
23. 00	Subtotal (line 21 minus line 22)	4, 021, 741	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	o	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	4, 021, 741	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Recovery of Accelerated Depreciation	0	31. 99
32.00	Total amount payable to the provider (see instructions)	4, 021, 741	32.00
32. 01	Sequestration adjustment (see instructions)	80, 435	32. 01
33.00	Interim payments	3, 956, 378	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)	-15, 072	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24, 873	36.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
		87, 849	
51. 00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52. 00	The rate used to calculate the Time Value of Money	0.00	
53.00	Time Value of Money (see instructions)	ΟĮ	53. 00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150011	Peri od: From 07/01/2015 Worksheet E-3 Part VI To 06/30/2016 Date/Time Prepared: 11/23/2016 9: 25 am

		Т	o 06/30/2016	Date/Time Pre 11/23/2016 9:	
		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	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES]
1.00	Inpatient hospital/SNF/NF services		668, 559		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		668, 559	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		668, 559	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				1
8.00	Routi ne servi ce charges		630, 349		8. 00
9.00	Ancillary service charges		737, 481	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 367, 830	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
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	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		1, 367, 830	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	699, 271	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	
20. 00	Cost of physicians' services in a teaching hospital (see instru		0	0	20. 00
21. 00	·	,	668, 559	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		((0, 550	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		668, 559	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	20.00
30. 00 31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		668, 559	0	
32. 00	Deductibles		000, 559	0	32.00
33. 00	Coinsurance		0	0	33. 00
34. 00			0	0	34.00
35. 00	·		0	U	35. 00
36. 00			668, 559	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	000, 559	0	1
38. 00			668, 559	0	
39. 00	· ·		000, 337	O	39. 00
40. 00			668, 559	0	1
41. 00				0	41.00
41.00				0	1
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15_2	-2, 268 0	0	1
- 3.00	chapter 1, §115.2	C WI LII OWS I UD 13-2,			75.00
	OVERRI DES				1
109, 00	Override Ancillary service charges (line 9)		0	0	109. 00
	1		-1	_	

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	eu of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 1500 Component CCN: 15	011 Period: From 07/01/2015 T011 To 06/30/2016	Date/Time Pre	pared:
	Title XIX	Subprovi der - I RF	11/23/2016 9: Cost	25 am
	<u>.</u>	I npati ent	Outpati ent	
		1. 00	2. 00	

	IRF	1	
	Inpatient	Outpati ent	
	1. 00	2. 00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	X SERVICES		
COMPUTATION OF NET COST OF COVERED SERVICES			
On Inpatient hospital/SNF/NF services	0		1. (
00 Medical and other services		0	2. (
OO Organ acquisition (certified transplant centers only)	0		3. (
OO Subtotal (sum of lines 1, 2 and 3)	0	0	4. (
OO Inpatient primary payer payments	0		5. (
Outpatient primary payer payments	Ŭ	0	6. (
OU Subtotal (line 4 less sum of lines 5 and 6)	0	Ö	7. (
COMPUTATION OF LESSER OF COST OR CHARGES	<u> </u>	0	7. (
Reasonable Charges			0 (
Routine service charges	0		8. (
Ancillary service charges	0	0	9. (
00 Organ acquisition charges, net of revenue	0		10. (
00 Incentive from target amount computation	0		11. (
00 Total reasonable charges (sum of lines 8 through 11)	0	0	12. (
CUSTOMARY CHARGES			
00 Amount actually collected from patients liable for payment for services on a charge	0	0	13. (
basi s			
00 Amounts that would have been realized from patients liable for payment for services on	0	0	14. (
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
00 Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15. (
00 Total customary charges (see instructions)	0	0	16. (
00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	17. (
line 4) (see instructions)			
00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. (
16) (see instructions)			
00 Interns and Residents (see instructions)	0	o	19. (
00 Cost of physicians' services in a teaching hospital (see instructions)	o	0	20. (
00 Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21. (
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide		_	
OO Other than outlier payments	0	0	22. (
00 Outlier payments	0	0	23. (
00 Program capital payments	o o	Ĭ	24. (
00 Capital exception payments (see instructions)	o		25. (
00 Routine and Ancillary service other pass through costs	0	0	26. (
	0	0	
00 Subtotal (sum of lines 22 through 26)	1	0	27. (
OO Customary charges (title V or XIX PPS covered services only)	0	- 1	28.
OU Titles V or XIX (sum of lines 21 and 27)	0	0	29. (
COMPUTATION OF REIMBURSEMENT SETTLEMENT		_	
00 Excess of reasonable cost (from line 18)	0	0	30. (
00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	- 1	31. (
00 Deductibles	0	0	32. (
00 Coi nsurance	0	0	33. (
00 Allowable bad debts (see instructions)	0	0	34. (
00 Utilization review	0		35. (
00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36. (
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. (
00 Subtotal (line 36 ± line 37)	0	Ö	38.
Direct graduate medical education payments (from Wkst. E-4)	O	Ĭ	39.
00 Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.
00 Interim payments	0	0	41. (
	0	0	41. (
	-	- 1	
00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43. (
chapter 1, §115.2			
OVERRI DES			
.00 Override Ancillary service charges (line 9)	O	^	109.0

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

			'	0 00, 00, 2010	11/23/2016 9:	25 am
		General Fund	Speci fi c	Endowment Fund	Pl ant Fund	
			Purpose Fund			
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1. 00	Cash on hand in banks	26, 241, 190		0	0	1. 00
2.00	Temporary investments	3, 900, 911	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	53, 524, 601	0	0	0	4. 00
5.00	Other recei vable	1, 691, 428	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-34, 282, 223	0	0	0	6. 00
7.00	Inventory	1, 505, 584		0	0	7. 00
8.00	Prepai d expenses	2, 194, 280	0	0	0	8. 00
9.00	Other current assets	795, 880	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	55, 571, 651	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	4, 646, 548			0	
13.00	Land improvements	3, 353, 531	0	0	0	13.00
14.00	Accumul ated depreciation	-2, 172, 862	0	0	0	14. 00
15. 00	Bui I di ngs	113, 907, 381		0	0	15. 00
16.00	Accumul ated depreciation	-64, 263, 711	0	0	0	16. 00
17. 00	Leasehold improvements	2, 473, 673	0	0	0	17. 00
18.00	Accumul ated depreciation	-916, 091	0	0	0	18. 00
19.00	Fi xed equipment	1, 005, 608	0	0	0	19. 00
20.00	Accumul ated depreciation	-870, 167	0	0	0	20. 00
21.00	Automobiles and trucks	1, 070, 672	0	0	0	21. 00
22.00	Accumul ated depreciation	-622, 641	0	0	0	22. 00
23.00	Major movable equipment	77, 622, 878	0	0	0	23. 00
24.00	Accumul ated depreciation	-62, 202, 369	0	o	0	24. 00
25.00	Mi nor equipment depreciable	0	0	o	0	25. 00
26.00	Accumul ated depreciation	0	0	o	0	26. 00
27.00	HIT designated Assets	0	0	o	0	27. 00
28.00	Accumul ated depreciation	0	0	o	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	8, 665, 003	0	o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	81, 697, 453	0	o	0	30.00
	OTHER ASSETS			'		
31.00	Investments	206, 284, 018	10, 155	0	0	31. 00
32.00	Deposits on Leases		0	o	0	32. 00
33.00	Due from owners/officers		0	o	0	33. 00
34.00	Other assets	8, 916, 922	0	ol	0	34.00
35. 00	Total other assets (sum of lines 31-34)	215, 200, 940		o	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	352, 470, 044			0	36. 00
	CURRENT LIABILITIES		,	-1		
37.00	Accounts payable	4, 676, 289	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	8, 618, 051		o	0	38. 00
39. 00	Payroll taxes payable	0	0	o	0	39. 00
40.00	Notes and Loans payable (short term)		0	ol	0	40.00
41.00	Deferred income	1	0	ol	0	41.00
42. 00	Accel erated payments		_	-		42.00
43. 00	Due to other funds		0	ol	0	
44. 00	Other current liabilities	4, 975, 491	l o	ol	0	•
45. 00	Total current liabilities (sum of lines 37 thru 44)	18, 269, 831	•	_		
	LONG TERM LIABILITIES	,		-1		
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable		0	ol	0	•
48. 00	Unsecured Loans		0	ol	0	48. 00
49. 00	Other long term liabilities	94, 029, 897	0	ol	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	94, 029, 897		_	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	112, 299, 728			0	
	CAPI TAL ACCOUNTS			-1		
52.00	General fund balance	240, 170, 316				52. 00
53. 00	Specific purpose fund		10, 155			53. 00
54. 00	Donor created - endowment fund balance - restricted		.5, .50	o		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			l ol		55. 00
56. 00	Governing body created - endowment fund balance			o		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
55. 55	replacement, and expansion				O	55. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	240, 170, 316	10, 155	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	352, 470, 044		l	0	60.00
	59)]		ŭ	
		•		. '		•

Provider CCN: 150011

| Peri od: | Worksheet G-1 | From 07/01/2015 | To 06/30/2016 | Date/Time Prepared:

					To 06/30/2016	Date/Time Pre 11/23/2016 9:	
		General	Fund	Special P	urpose Fund	Endowment Fund	20 4111
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		234, 937, 237		10, 155		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5, 233, 079				2. 00
3.00	Total (sum of line 1 and line 2)		240, 170, 316		10, 155	5	3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0		()	10. 00
11. 00	Subtotal (line 3 plus line 10)		240, 170, 316		10, 155	1	11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0	0	12. 00
13. 00		0		(0	0	13. 00
14. 00		0		(0	0	14. 00
15. 00		0		1	0	0	15. 00
16.00		0		9	0	0	16.00
17. 00	T-+-1 d-d+i (£ li 10 17)	U	0	1	0	J	17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		040 170 217		10, 155		18. 00 19. 00
19.00	sheet (line 11 minus line 18)		240, 170, 316		10, 155		19.00
	Sheet (Title II millus IIIle 10)	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0	_		0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		U		0		9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	١	0	·	U		12.00
13. 00	beductions (debit adjustments) (specify)		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	o	O		0		18. 00
19. 00	Fund balance at end of period per balance	o		•	Ö		19. 00
	sheet (line 11 minus line 18)						
	,			•	•	'	•

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

			10 06/30/2016	11/23/2016 9:		
	Cost Center Description	Inpatient	Outpati ent	Total	25 alli	
	3331 3311131 33331 1 21 311	1. 00	2. 00	3. 00		
	PART I - PATIENT REVENUES			2. 22		
	General Inpatient Routine Services					
1.00	Hospi tal	18, 768, 86	4	18, 768, 864	1. 00	
2.00	SUBPROVI DER - I PF	4, 024, 14	4	4, 024, 144	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, 793, 00	8	22, 793, 008	10.00	
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	8, 773, 21	2	8, 773, 212		
12. 00	CORONARY CARE UNIT				12. 00	
13. 00	BURN INTENSIVE CARE UNIT				13. 00	
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00	
15. 00	OTHER SPECIAL CARE (SPECIFY)			0 770 040	15. 00	
16. 00	Total intensive care type inpatient hospital services (sum of lin	es 8, 773, 21	2	8, 773, 212	16. 00	
17 00	11-15)	21 5// 22		21 5// 220	17.00	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	31, 566, 22		31, 566, 220		
18.00	Ancillary services	80, 342, 92		80, 342, 929	18. 00	
19.00	Outpatient services RURAL HEALTH CLINIC		0 282, 254, 249	282, 254, 249		
20. 00 21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	20. 00 21. 00	
21.00	HOME HEALTH AGENCY		U	U	22. 00	
23. 00	AMBULANCE SERVICES		0 4, 354, 276	4, 354, 276		
24. 00	CMHC		4, 334, 270	4, 334, 270	24. 00	
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00	
26. 00	HOSPI CE				26. 00	
27. 00	PHYSI CI AN		0 24, 803, 462	24, 803, 462		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 111,909,14		423, 321, 136		
20.00	G-3, line 1)		,	120, 021, 100	20.00	
	PART II - OPERATING EXPENSES	1	<u>'</u>			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		163, 882, 415		29. 00	
30.00			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	ELI MI NATI ONS	948, 87			37. 00	
38. 00			0		38. 00	
39. 00			0		39. 00	
40.00			0		40.00	
41. 00	T		0		41. 00	
42.00	Total deductions (sum of lines 37-41)		948, 870		42. 00	
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ranster	162, 933, 545		43. 00	
	to Wkst. G-3, line 4)	I	l l			

Health Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10						
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 150011 Period:			Worksheet G-3		
			From 07/01/2015 To 06/30/2016	Date/Time Pre 11/23/2016 9:2		
				1.00		
1.00	Total notions revenues (from Wkat C 2 Dont L column 2 Line	20)		1. 00 423, 321, 136	1. 00	
2.00				259, 817, 317	2. 00	
3. 00	Net patient revenues (line 1 minus line 2)			163, 503, 819	3. 00	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		162, 933, 545	4. 00	
5. 00	Net income from service to patients (line 3 minus line 4)	,		570, 274	5. 00	
5.00	OTHER I NCOME			370, 214	3. 00	
6.00	Contributions, donations, bequests, etc			0	6. 00	
7. 00	Income from investments			1, 977, 581	7. 00	
8.00				0	8. 00	
9.00				0	9. 00	
10.00	00 Purchase discounts			0	10.00	
11. 00	00 Rebates and refunds of expenses			0	11.00	
12.00	·			0	12.00	
13.00				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	
	Revenue from sale of medical and surgical supplies to other than patients			0	16.00	
	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	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
20.00				0	20.00	
21. 00				0	21. 00	
22. 00	Rental of hospital space			0	22. 00	
23. 00				0	23.00	
24. 00				3, 028, 600		
25. 00	Total other income (sum of lines 6-24)			5, 006, 181		
	00 Total (line 5 plus line 25)			5, 576, 455		
	DO BAD DEBT EXPENSE			343, 376		
	0 Total other expenses (sum of line 27 and subscripts)			343, 376		
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	5, 233, 079	29. 00	

Heal th	Financial Systems MARION GENERAL H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150011	Peri od: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Pre 11/23/2016 9:	pared:
Title XVIII Hospital					20 4
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
4 00	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 225, 274 0	1.00
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			19, 167	1. 01 2. 00
2.00	Model 4 BPCI Capital DRG outlier payments			19, 107	2.00
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			49. 70	1
4. 00	Number of interns & residents (see instructions)			0.00	1
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (Worksheet E	, part A line	0. 00	7. 00
8. 00	30) (see instructions)	tions)		0.00	8. 00
9. 00	Percentage of Medicaid patient days to total days (see instructions)			0.00	
10.00				0.00	
11. 00				0.00	11.00
12. 00			1, 244, 441	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	4. 00 5. 00
6.00	Percentage adjustment for extraordinary circumstances (see ins	tructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary		line 6)	0.00	1
8. 00	Capital minimum payment level (line 5 plus line 7)	01. Game (ae 2 /		0	8.00
9. 00	Current year capital payments (from Part I, line 12, as applic	abl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to ca		less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)	pital payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital pay	ments (line 10 plus lir	e 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over ca (if line 12 is negative, enter the amount on this line)			0	1
15. 00	Current year allowable operating and capital payment (see inst	ructi ons)		0	15. 00
16. 00		- /		0	16. 00
17. 00	Current year exception offset amount (see instructions)			0	17. 00