Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost repor					FORM APPROVED OMB NO. 0938- EXPI RES 05-31	0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	RT CERTIFICATION	Provider C	CN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Pre 11/26/2018 2:	
PART I – COST REPORT STATUS						
Provider 1. [X] Electronically filed cost rep				Date: 11/26/2	018 Time: 2	2:47 pm
use only 2. [] Manually submitted cost repor						
3.[0] f this is an amended report 4.[F]Medicare Utilization. Enter '	enter the number 'F" for full or "l	of times th L" for low.	e provider re	submitted this c	ost report	
	Recei ved:			PR Date:		
use only (1) As Submitted 7. Contr	actor No.		11. Co	ontractor's Vendo	or Code:	4
(2) Settled without Audit 8. [N]	Final Report for	or this Provid	ar CCN 12. [
(5) Settled with Addit	тпа керот тог	this Floviu		number of tin	nes reopened =	0-9.
(4) Reopened						
(5) Amended						
PART II - CERTIFICATION			I			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI	ON CONTAINED IN T	THIS COST REP	PORT MAY BE PL	INLSHABLE BY CRU	ALNAL CLVLLAN	JD
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O						
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	Y RESULT.					
CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	R ADMINISTRATOR OF	F PROVIDER(S)			
I HEREBY CERTIFY that I have read the above	e certification st	tatement and	that I have	examined the acc	ompanyi ng	
electronically filed or manually submitted	cost report and t	the Balance 3	Sheet and Sta	tement of Revenu	e and	
Expenses prepared by MARION GENERAL HOSPITA						
ending 06/30/2018 and to the best of my kno	wledge and belief	f, this repo	rt and statem	ent are true, co	rrect,	
complete and prepared from the books and re						
except as noted. I further certify that I						
health care services, and that the services	s identified in th	nis cost rep	ort were prov	ided in complian	ce with such	
laws and regulations.						
[]I have read and agree with the above o	certification sta	tement I ce	rtify that I	intend my electr	onic	
signature on this certification stater						
- -			5 1		5	
	(Si gned	/	or or Adminic	strator of Provid	lor(c)	
		UTITC	er of Auminis			
		Title				
		nue				
		Date				
		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	НІТ	Title XIX	

	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	-337, 020	98, 457	0	-278, 229	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-15, 909	0		18, 030	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	-352, 929	98, 457	0	-260, 199	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	IA	Provi de	er CCN:	15-0011	Period: From 07/01/ To 06/30/		Workshe Part I Date/Ti 11/26/2	ime Pre	epare
	1.00	2.	00		3.00			4.00	11/20/	2010 2.	
	Hospital and Hospital Health Care Co										
00	Street: 441 WABASH AVENUE	PO Box:			44050	0					1.
00	City: MARION	State: I Component Na		CCN	2: 46952 CBSA	Provi der	ty: GRANT Date	Daym	ent Syst	om (D	2.
				Jumber	Number		Certified	1 2	, 0, or		
						.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		V.	XVIII		1
		1.00		2.00	3.00	4.00	5.00	6.00	-	8.00	
	Hospital and Hospital-Based Componen						1		1		
00		MARION GENERAL HO	OSPI TAL 1	50011	99915	1	07/01/1966	N	P	0	3.
00 00	Subprovider - IPF Subprovider - IRF	MARION GENERAL HO REHAB	OSPI TAL 1	5T011	99915	5	07/01/2005	N	P	0	4. 5.
00	Subprovider - (Other)										6.
00	Swing Beds - SNF										7.
0C	Swing Beds - NF										8.
00	Hospital-Based SNF										9.
. 00	Hospi tal -Based NF Hospi tal -Based OLTC										10.
. 00	Hospi tal -Based HHA										12.
00	Separately Certified ASC										13.
00	Hospi tal -Based Hospi ce										14.
00	Hospital-Based Health Clinic - RHC										15.
00	Hospital-Based Health Clinic - FQHC										16.
00 00	Hospital-Based (CMHC) I Renal Dialysis										17.
00	Other										19.
		1					From:		Тс):	
							1.00		2.		
00 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						07/01/2	017	06/30	/2018	20. 21.
00	Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord								N	1	22.
	for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				21 100(0)(2)(11010					
01	Did this hospital receive interim un				s cost	reporti ng	N		Y	/	22.
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	eporting period o	ccui i i iig i	un un a	itei uc	tober 1.					
02	Is this a newly merged hospital that	requires final u	Incompensa	ted car	e paymei	nts to be	N		Ν	I	22.
	determined at cost report settlement						s				
	or "N" for no, for the portion of th		• •								
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of the	cost r	eporting	g period o	n				
03	Did this hospital receive a geograph	i c. reclassi fi cati	on from u	rban to	rural a	as a resul	t N		Ν	ı	22.
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						e				
	cost reporting period occurring on o hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,			ounred		i dance in t					
00	Which method is used to determine Me							3	Ν	I	23.
	1, enter 1 if date of admission, 2 i										
	method of identifying the days in th used in the prior cost reporting per										
	used in the piror cost reporting per		In-State			Out-of		ledi ca	id 0	ther	
			Medi cai d		cai d	State	State H	IMO da	ys Med	di cai d	
			paid days	· ·			Medi cai d		0	days	
				unpa day		aid days	el i gi bl e unpai d				
			1.00	2.0		3.00	4.00	5.00		5.00	-
	If this provider is an IPPS hospital	, enter the	37	_	1, 443	0	0		352		24.
00		n 1, in-state									
00	in-state Medicaid paid days in colum										
00	Medicaid eligible unpaid days in col										
00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c			1							
00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai	d days in column					1		1		
00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	d days in column t unpaid days in									
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	d days in column t unpaid days in column 6.	1	6	8	0	0		57		25.
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	d days in column t unpaid days in column 6. e in-state	1	6	8	0	0		57		25.
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	d days in column t unpaid days in column 6. e in-state in-state umn 2,	1	6	8	Ο	0		57		25.
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column	d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	1	6	8	O	O		57		25.
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	1	6	8	O	O		57		25

SPI T	Financial Systems MAR AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		AL HOSPITAL Provider CO	CN: 15-0011	Period: From 07/01/201 To 06/30/201	7 Part I 8 Date/Ti	eet S-2 me Prepa	barec
					Urban/Rural		2018 2:38 Geogr	<u>88 pr</u>
00	Fature standard assessible along fighting (not				1.00	2.0		24
	Enter your standard geographic classification (not cost reporting period. Enter "1" for urban or "2" Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urbar	for rural. t wage) sta	atus at the end	d of the cost		2		26. 27.
. 00	enter the effective date of the geographic reclass If this is a sole community hospital (SCH), enter effect in the cost reporting period.			CH status in		1		35.
					Begi nni ng: 1.00	Endi 2.0		
00	Enter applicable beginning and ending dates of SCH of periods in excess of one and enter subsequent d		Subscript line	36 for numbe				36.
	If this is a Medicare dependent hospital (MDH), en is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for				N	0		37. 37.
	accordance with FY 2016 OPPS final rule? Enter "Y" instructions)	for yes o	or "N" for no.	(see	N			
00	If line 37 is 1, enter the beginning and ending da greater than 1, subscript this line for the number enter subsequent dates.							38.
					Y/N 1.00	Y/ 2.0		
00	Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2) for yes or "N" for no. Does the facility meet the with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in col	(i) or (ii mileage re)? Enter in co equirements in	olumn 1 "Y" accordance	e N	N		39.
00	instructions) Is this hospital subject to the HAC program reduct "N" for no in column 1, for discharges prior to Oc- na in column 2, for discharges on often October	ctober 1. I	Enter "Y" for y			Y	,	40
	no in column 2, for discharges on or after October	1. (see l	nstructions)			V XVIII 00 2.00	XI X 3.00	
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital pay	ment for (di sproporti opa	to sharo in a	ccordance	N N	N	45
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W	exception 1	for extraordina	ary circumsta	nces 1	N N		46.
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PF Is the facility electing full federal capital paym					N N N N		47 48
00	Teaching Hospitals Is this a hospital involved in training residents	in approve	ed GME programs	s? Enter "Y"	for yes	N		56
00	or "N" for no. If line 56 is yes, is this the first cost reportin GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first m for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt.	for yes ou month of th s "Y", comp	r "N" for no in his cost repor plete Workshee	n column 1. I ting period?	f column 1 Enter "Y"			57
00	If line 56 is yes, did this facility elect cost re defined in CMS Pub. 15-1, chapter 21, §2148? If ye	eimbursemei	nt for physicia	ans' services	as 1	N		58
00	Are costs claimed on line 100 of Worksheet A? If			Pt. I.	r	N		59
				NAHE 413.85 Y/N	5 Worksheet A Line #	Pass-Tl Qualifi Criteri	cation	
00	Are you claiming nursing and allied health educati	on (NAHE)	costs for	1.00 N	2.00	3.		60
	any programs that meet the criteria under §413.85?			Direct GME	IME	Direc		
		1.00	2.00	3.00	4.00	5.0	00	
00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		2100		0.		0.00	61
01	Enter the average number of unweighted primary car FTEs from the hospital's 3 most recent cost report ending and submitted before March 23, 2010. (see							61
02	instructions) Enter the current year total unweighted primary ca FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of							61
	ACA). (see instructions)							

V/N IME Direct GME IME 61.04 Enter the number of unweighted primary care/or surgery all opathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 1.00 2.00 3.00 4.00 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE south the current year's primary care and/or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE count D 61.06 Of the FTEs in Line 61.05, specify each new program specially, if any, and the number of FTE residents for each new program name. Enter in colum 2, the program code. Enter in colum 3, the IME FTE unweighted count. 1.00 2.00 3.00 61.20 Of the FTEs in Line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each new program name. Enter in colum 1, the program name. Enter in colum 3, the IME FTE unweighted count. 0.00 0.00 61.20 Of the FTEs in Line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each new program code. Enter in columan, 3, the IME FTE unweighted count. 0.00 0.00 61.20 Of the FTEs in Line 61.05, specify each expanded program special ty, if any, and the number of TTE residents for each expanded program (see instructions) 0.00 61.20 Of the UME FTE unweigh	u of Form CMS-25 Worksheet S-2 Part I Date/Time Prepa 11/26/2018 2:38	iod: m 07/01/2017		Provi der CC	TA	LEX IDENTIFICATION DA	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMP		
61.04 Enter the number of unweighted primary care/or surgery all opathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Image: Content of Content	Direct GME	IME	Direct GME	IME	Y/N				
61.04 Enter the number of unweighted primary care/or surgery all opathic and/or ostopathic FTEs in the current cost reporting period. (see instructions). Image: Content of the stability of the stabili	5.00	4 00	3.00	2 00	1 00				
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.03). (see instructions) 61.06 Enter the amount of ACA §503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 700 2.00 3.00 0 0 0.00 0 0 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0.00	2.00		athic FTEs in the ee instructions).	surgery allopathic and/or osteop current cost reporting period. (s		
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE Count 61.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 4, the direct GME FTE unweighted count. 0.00 61.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. 0.00 62.00 Enter The unweighted count.						the current year's ery FTE counts (line structions)	and/or general surgery FTEs and primary care and/or general surg 61.04 minus line 61.03). (see in		
61.10 Of the FTEs in Line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 1, the program name. 0.00 61.20 Of the FTEs in Line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. 0.00 Enter in column 1, the program name. Enter in column 1, the program name. 0.00 Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. 0.00 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period of HRSA ThC program. (see instructions) 63.00 Has your facility trained residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings. 64.00 Enter in column 1, if yes, complete lines 64 through 67. (see instructions). 64.00 Enter in column 1, if yes, ory und facility trained residents in Nonprovider SettingsThis base year is your cost re period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your fac						that are nonprimary	used for cap relief and/or FTEs	61.06	
61.10 Of the FTES in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the LME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 0.00 61.20 Of the FTES in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct ion colume of FTE residents that your hospital trained in this cost reporting period for which your hospital scattering period of HRSA HCR. Funding (see instructions) 62.00 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA HCR. Funding (see instructions) 63.00 Has your facility trained residents in Nonprovider Settings 63.00 Extern in column 1, if yes, complete lines 64 through 67. (see instructions) 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1, if line 64 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column	Direct GME FTE Count	FTE Count E			Pro				
special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Heal th Resources and Services Administration (HRSA) 62:00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62:01 Enter the number of FTE residents that rotated from a Teaching Heal th Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospital's that Claim Residents in Nonprovider Settings 63:00 Has your facility trained residents in nonprovider Settings for (see instructions) Teaching Hospital's that Claim Residents in Nonprovider Settings 64:00 Enter in column 1. If yes, complete lines 64 through 67. (see instructions) Teaching Hospital Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings-This base year is your cost re period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 21the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1+ column 2)). (see instructions)	4.00		2.00	1.00		fu aaah naw naaram	Of the FTFe in Line (1 OF energi	(1 10	
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) 62.00 Has your facility trained residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings of 0.00 64.00 Enter in column 1, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00				r of FTE residents uctions) Enter in r in column 2, the the IME FTE	specialty, if any, and the number for each new program. (see instr column 1, the program name. Enter program code. Enter in column 3, unweighted count. Enter in colum	01.10	
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted FTEs in Hospital Wheele the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost report of that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost report of that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.00 0.00 64.00 Enter in colu	0.00	0.00				he number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,	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 of 3, the IME FTE unweighted count.		
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during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted Unweighted Vieweighted Unweighted FTEs in Nonprovider FTEs in Nonprovider Hospital Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reperiod that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 in the base year period, the number of unweighted non-primary care 0.00 0.00 0.00 resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unweighted Unweighted Program Name Program Code Unweighted Unweighted Inweighted	0.00				tions)	funding (see instruc	your hospital received HRSA PCRE		
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted "Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reperiod that begins on or after July 1, 2009 and before June 30, 2010. 1.00 2.00 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.00 in the base year period, the number of unweighted non-primary care 0.00 0.00 0.00 0.00 0.00	0.00			<u>e instruction</u>	ram. (s	riod of HRSA THC prop	during in this cost reporting pe		
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Nonprovider Site Hospital 64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reperiod that begins on or after July 1, 2009 and before June 30, 2010. 0.00	Ratio (col. 1/	Unweighted F	Unwei ghted	or through o					
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Program Name Program Code Unweighted Unweighted R				3 the ratio	column	ur hospital. Enter ir	resident FTEs that trained in yo		
Nonprovider Hospital	Ratio (col. 3/ (col. 3 + col. 4))	FTEs in (FTĔs Nonprovi der						
Si te 1.00 2.00 3.00 4.00	5.00	4.00		2.00		1 00			

	.EX IDENTIFICATION D	ATA Provider	Fr	eriod: com 07/01/2017		
			To	06/30/2018	Date/Time Pre 11/26/2018 2:	pared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
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5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs	FTEs in	$(\operatorname{col} \cdot 1 + \operatorname{col} \cdot$	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current N beginning on or after July 1, 201		n Nonprovider Settir				
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima	ry care resident				
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	column 2)). (see in	structions)				
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Health Financi	al Systems MARION GENERAL HOSPITAL		In Lie	u of Form CMS-	2552-10	
HOSPITAL AND F	IOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-007		riod: om 07/01/2017 06/30/2018	Worksheet S-2 Part I Date/Time Pre 11/26/2018 2:	epared:	
				1.00		
80.00 Is this 81.00 Is this "Y" for	rm Care Hospital PPS a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. a LTCH co-located within another hospital for part or all of the cost repo yes and "N" for no.	orting p	eriod? Enter	N N	80. 00 81. 00	
85.00 Is this 86.00 Did this	roviders a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for s facility establish a new Other subprovider (excluded unit) under 42 CFR S (f)(1)(ii)? Enter "Y" for yes and "N" for no.		"N" for no.	N	85. 00 86. 00	
87.00 Is this	(1)(1)(1): Enter 1 for yes and a for no. hospital an extended neoplastic disease care hospital classified under sec (1)(B)(vi)? Enter "Y" for yes or "N" for no.	ction		Ν	87.00	
		-	V 1.00	XI X 2.00	_	
	and XIX Services					
	s facility have title V and/or XIX inpatient hospital services? Enter "Y" 'N" for no in the applicable column.	for	N	Y	90.00	
91.00 Is this	hospital reimbursed for title V and/or XIX through the cost report either in part? Enter "Y" for yes or "N" for no in the applicable column.	in	Ν	Y	91.00	
92.00 Are tit	e XIX NF patients occupying title XVIII SNF beds (dual certification)? (se tions) Enter "Y" for yes or "N" for no in the applicable column.	e		Ν	92.00	
93.00 Does thi	is facility operate an ICF/IID facility for purposes of title V and XIX? En yes or "N" for no in the applicable column.	nter	Ν	Ν	93.00	
94.00 Does ti	tle V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the		Ν	Ν	94.00	
95.00 If line 96.00 Does ti	applicable column. 00 1f line 94 is "Y", enter the reduction percentage in the applicable column. 0.0 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 0.0					
97.00 If line 98.00 Does ti stepdow	applicable column. 0.00 1f line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in 0.00					
98.01 Does ti C, Pt.	column 1 for title V, and in column 2 for title XIX.1 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for				98. 01	
bed cos	tle V or XIX follow Medicare (title XVIII) for the calculation of observati ts on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column		Y	Y	98. 02	
98.03 Does ti reimburs	e V, and in column 2 for title XIX. tle V or XIX follow Medicare (title XVIII) for a critical access hospital (sed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in col		Ν	Ν	98. 03	
98.04 Does ti outpati	e V, and in column 2 for title XIX. tle V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of ent services cost? Enter "Y" for yes or "N" for no in column 1 for title V,	and	Ν	Ν	98. 04	
98.05 Does ti Wkst. C	nn 2 for title XIX. tle V or XIX follow Medicare (title XVIII) and add back the RCE disallowanc Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, a		Y	Y	98.05	
98.06 Does ti Pts. I column	2 for title XIX. tle V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in 2 for title XIX.		Y	Υ	98.06	
105.00 Does th	roviders s hospital qualify as a CAH?		N		105.00	
	facility qualifies as a CAH, has it elected the all-inclusive method of pa patient services? (see instructions)	ayment	N		106.00	
trai ni n	facility qualifies as a CAH, is it eligible for cost reimbursement for L&R g programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) e GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is) If	Ν		107.00	
108.00 Is this	sed. If yes complete Wkst. D-2, Pt. II. a rural hospital qualifying for an exception to the CRNA fee schedule? Se tion §412.113(c). Enter "Y" for yes or "N" for no.	ee 42	Ν		108. 00	
CIT SEC	Physi cal Occupat		Speech	Respi ratory		
therapy	1.00 2.0 hospital qualifies as a CAH or a cost provider, are services provided by outside supplier? Enter "Y" or "N" for no for each therapy. N		3.00 N	4.00 N	109.00	
				1.00	-	
Demonst	s hospital participate in the Rural Community Hospital Demonstration projec ration)for the current cost reporting period? Enter "Y" for yes or "N" for e Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 ple.	no. If	yes,	N	110.00	

alth Financial Systems MARION GENERAL)SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPITAL Provider CCN: 15		Period:		u of For Workshe		
			rom 07/01/2 To 06/30/2		Part I Date/Ti 11/26/2		
	·		1.00				-
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting period umn 1 is Y, enter icipating in colum	d? Enter the nn 2.	1.00 N		2.0		111. (
				1.00	2.00	3.00	1
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" f 17.00 Is this facility legally-required to carry malpractice insura	If column 2 is "E' for long term car based on the def for yes or "N" for	', enter re (inclu finition no.	in column des in CMS	N Y Y		0	115. 0
no. 18.00 Is the malpractice insurance a claims-made or occurrence poli		5		r 1			117. (
claim-made. Enter 2 if the policy is occurrence.	Pr	remiums	Losses	5	Insura	ance	
		1.00	2.00		3. C		-
18.01 List amounts of malpractice premiums and paid losses:		1, 185, 52	2	0		0	0118.
8.02 Are malpractice premiums and paid losses reported in a cost o	contor other than t	the	1.00 N		2.0	0	118.
Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment	Harmless provision column 1, "Y" for alifies for the Out	n in ACA yes or tpatient	Y		Y		119. 120.
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implar			N				121.
patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν	-			122.
Transplant Center Information 5.00Does this facility operate a transplant center? Enter "Y" for	wee and "N" for r	po lf	N				125.
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 f this is a Medicare certified kidney transplant center, ent	er the certificati						125.
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter	er the certification	on date					127.
in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certificatio	on date					128.
P. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certification						129.
0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in column 2 and termination date, and transplant center.	umn 2.						130.
1.00 f this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 2.00 f this is a Medicare certified islet transplant center, enter	umn 2.						131.
in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified other transplant center, enter	er the certification						133.
in column 1 and termination date, if applicable, in column 2. 4.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.		umn 1					134.
Al I Provi ders		45 4					1
0.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y			N				140.

leal th Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	MARION GENER X IDENTIFICATION DATA	Provider CC	N: 15-001			Worksheet S- Part I	epared:
1.00	2.	00			3.00	11/20/2018 2	. <u>36 piii</u>
If this facility is part of a cha				he name a	and address	of the	
home office and enter the home of 41.00Name:	<u>fice contractor name and</u> Contractor's Name:	contractor numbe		actor's	Numbors		141.00
42.00 Street:	PO Box:		Contr	actor S	Number.		141.00
43. 00 Ci ty:	State:		Zip C	code:			143.00
44.00 Ana provider based physicians' and	to included in Wenkeheet	12				1.00 Y	144.00
44.00 Are provider based physicians' cos	sts filtraded fill worksheet	A :				T	144. 00
					1.00	2.00	1
 45.00 If costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility imperiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodological for the service of the factor of the	for yes or "N" for no in clude Medicare utilization for no in column 2. gy changed from the previo	n column 1. lf c n for this cost pusly filed cost	column 1 i reporting report?	3	Ν		145. 0
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		15-2, chapter 4	10, §4020)				
						1.00	
47.00 Was there a change in the statisti						N	147.0
48.00 Was there a change in the order of				for so		N N	148.0
49.00 Was there a change to the simplifi	eu cost finaling method? I	Part A	Part		Title V	Title XIX	149.0
		1.00	2.00		3.00	4.00	
Does this facility contain a prov							
or charges? Enter "Y" for yes or	'N" for no for each compo			B. (See			
55.00 Hospital 56.00 Subprovider - IPF		N N	N N		N N	N	155. C
57.00 Subprovi der – I RF		N	N		N	N	157.0
58. 00 SUBPROVI DER							158.0
59.00 SNF		N	N		N	N	159.0
60.00H0ME HEALTH AGENCY 61.00CMHC		N	N N		N N	N N	160. 0 161. 0
							101.0
						1.00	
Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more campu	ıses in di	fferent	CBSAs?	N	165. 0
	Name	County	State	Zip Cod	e CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0166.0
						1.00	-
Health Information Technology (HI	Γ) incentive in the Ameri	can Recovery and	d Rei nves	tment Act	:	1.00	
57.00 s this provider a meaningful use 58.00 f this provider is a CAH (line 10 reasonable cost incurred for the l	05 is "Y") and is a meaning	ngful user (line			er the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is i			qualify	for a ha	rdshi p		168.0
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N	' for no. (see i	nstructio	ons)	•		
69.00 If this provider is a meaningful u		d is not a CAH (line 105	is "N"),	enter the	0.0	0169. 0
transition factor. (see instruction	ліз <i>)</i>			-	Begi nni ng	Endi ng	
					1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and ending	date for the re	eporting	0	7/01/2015	09/30/2015	170. 0
					1.00	2.00	-
71.00 If line 167 is "Y", does this pro- section 1876 Medicare cost plans "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Ente		N		0171.0

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0011	Period: From 07/01/2017 To 06/30/2018		epared:
				Y/N	11/26/2018 2 Date	: 38 pili
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente	er all dates in t	the	
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS					-
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c					
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P		N			2.0
8. 00	yes, enter in column 2 the date of termination and in colum voluntary or "l" for involuntary. Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	g management ffices, drug er or its f the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00 . 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	or Compiled, ilable in	Y	A		4. C
. 00	those on the filed financial statements? If yes, submit rec					5.0
	,		•	Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	structions		Ν		7.0
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N		8.0
. 00	Are costs claimed for Interns and Residents in an approved		al education	Ν		9.0
0 00	program in the current cost report? If yes, see instruction					10.0
0.00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	r renewed in 1	ne current	N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11. 0
					Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Y	12.0
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13. (
4.00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	yes, see in	structions.	N	14.0
F 0-	Bed Complement				••	1.15
5.00	Did total beds available change from the prior cost reporti	<u> </u>	2 .		N N	15.0
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
6. 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 instructions)	Ν		N		16.0
7.00	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	10/10/2018	Y	10/10/2018	17. (
8. 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	Ν		Ν		18. (
9. 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.	Ν		Ν		19. (

	Financial Systems MARION GENER AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Date/Time F 11/26/2018	5-2 Prepared:
			ription	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS I	HOSPLTALS)		1	
	Capital Related Cost		1001111120)			
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense			ing the cost		23.00
23.00	reporting period? If yes, see instructions.		sai s made dui	The cost		23.00
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost re	porting period?		24.00
27.00	If yes, see instructions	sa mto during	und cost le	por tring periou?		24.00
25.00	Have there been new capitalized leases entered into during	the cost repo	rting period?	Plfves see		25.00
_0.00	instructions.	003t i opu				20.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	f ves see		26.00
_0.00	instructions.			. ,00, 000		20.00
27.00	Has the provider's capitalization policy changed during th	e cost reporti	na period? If	ves. submit		27.00
	copy.		5 1 2 2 2	J		
	Interest Expense					
28.00	Were new Loans, mortgage agreements or letters of credit e	ntered into du	ring the cost	reporting		28.00
	period? If yes, see instructions.		5	5		
29.00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service F	Reserve Fund)		29.00
	treated as a funded depreciation account? If yes, see inst	ructions				
30.00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If yes	s, see		30.00
	instructions.					
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes	s, see		31.00
	instructions.				<u> </u>	
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni sh	ed through co	ontractual		32.00
~~ ~~	arrangements with suppliers of services? If yes, see instr					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaini	ng to competi	tive bidding? If		33.00
	no, see instructions.				<u> </u>	
24.00	Provi der-Based Physi ci ans		h an an an air air an an an an		T	- 24.00
34.00	Are services furnished at the provider facility under an a	rrangement wit	n provider-ba	ised physicians?		34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	icting agroomo	nto with the	providor bacad		35.00
35.00	physicians during the cost reporting period? If yes, see i		ints with the	pi ovi dei -based		35.00
	physicians during the cost reporting period: in yes, see i			Y/N	Date	
	Home Office Costs			1.00	2.00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?					36.00
	Were home office costs claimed on the cost report?	repared by the	home office?	1.00		36.00
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	1.00		
37.00	Were home office costs claimed on the cost report?	. ,		1.00		
37.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions.	fice different	from that of	1.00		37.00
37. 00 38. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth	fice different d of the home	from that of office.	1.00		37.00
37. 00 38. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en	fice different d of the home	from that of office.	1.00		37.00 38.00
37.00 38.00 39.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home er chain compo	from that of office. nents? If yes	1.00		37.00 38.00
37.00 38.00 39.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.	fice different d of the home er chain compo	from that of office. nents? If yes	1.00		37.00 38.00 39.00
37.00 38.00 39.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home er chain compo home office?	from that of office. nents? If yes If yes, see	1.00	2.00	37.00 38.00 39.00
37.00 38.00 39.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions.	fice different d of the home er chain compo home office?	from that of office. nents? If yes	1.00		37.00 38.00 39.00
37.00 38.00 39.00 40.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	fice different d of the home er chain compo home office?	from that of office. nents? If yes If yes, see	1.00	2.00	37.00 38.00 39.00 40.00
37.00 38.00 39.00 40.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	fice different d of the home er chain compo home office?	from that of office. nents? If yes If yes, see	1.00	2.00	37.00 38.00 39.00
37.00 38.00 39.00 40.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	fice different d of the home er chain compo home office?	from that of office. nents? If yes If yes, see	1.00	2.00	37.00 38.00 39.00 40.00
 37. 00 38. 00 39. 00 40. 00 41. 00 	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home er chain compo home office?	from that of office. nents? If yes If yes, see	1.00	2.00	37. 00 38. 00 39. 00 40. 00 41. 00
 37. 00 38. 00 39. 00 40. 00 41. 00 	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	fice different d of the home er chain compo home office?	from that of office. nents? If yes If yes, see	1.00	2.00	37.00 38.00 39.00 40.00
 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home er chain compo home office?	from that of office. nents? If yes If yes, see	1.00	00	37. 00 38. 00 39. 00 40. 00 41. 00

Heal th	Financial Systems MARION GEN	ERAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0011	Period:	Worksheet S-2	
			From 07/01/2017 To 06/30/2018		
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	MANAGER			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	MARION GENERA	Provider CC	CN: 15-0011	Peri od:	Worksheet S-3	2552-10
					From 07/01/2017	Part I	
					To 06/30/2018	Date/Time Pre 11/26/2018 2:	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	80	29, 2	00 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		80	29, 2	0.00	0	
7.00	beds) (see instructions)		00	27,2	0.00	0	/.00
8.00	INTENSIVE CARE UNIT	31.00	19	6,9	35 0.00	0	8.00
9.00	CORONARY CARE UNIT	01100		0, ,	0100	Ū	9.00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36, 1	35 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0	0	16.00
17.00	SUBPROVIDER - IRF	41.00	18	6, 5	70	0	17.00
18.00	SUBPROVI DER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC					_	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		117				27.00
28.00	Observation Bed Days					0	
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0		0		31.00
32.00	Labor & delivery days (see instructions)		0		U		32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
55.00	LTCH site neutral days and discharges						33.01

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0011		eriod: com 07/01/2017 0 06/30/2018		pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time I	<u>11/26/2018_2:</u> Equi val ents	38 pm
	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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	7,057	374	14, 02	22			1.00
2.00	HMO and other (see instructions)	2,944	4, 795					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO IRF Subprovider	287	65					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7, 057	374	14, 02	22		-	7.00
8.00	INTENSIVE CARE UNIT	1, 152	0	3, 63	38			8.00
9.00	CORONARY CARE UNI T							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, 03	31			13.00
14.00	Total (see instructions)	8, 209	374	19, 69	91	0.00	700.02	14.00
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF	0	0		0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	2, 053	16	2, 68	81	0.00	15.58	17.00
18.00	SUBPROVI DER		0		0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPICE							24.00
24. 10	HOSPICE (non-distinct part)	0	0		0			24.10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00		•
27.00	Total (sum of lines 14-26)					0.00	715.60	•
28.00	Observation Bed Days		1, 003	2, 98	80			28.00
29.00	Ambulance Trips	1, 500						29.00
30.00	Employee discount days (see instruction)			12				30.00
31.00	Employee discount days - IRF				6			31.00
32.00	Labor & delivery days (see instructions)	0	0		0			32.00
32.01	Total ancillary labor & delivery room				0			32.01
	outpatient days (see instructions)							
33.00	LTCH non-covered days	0						33.00
33.01	LTCH site neutral days and discharges	0						33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	MARION GENERAL AL DATA	Provider CC	CN: 15-0011	Period:	u of Form CMS-2 Worksheet S-3	
					From 07/01/2017 To 06/30/2018	Part I Date/Time Pre 11/26/2018 2:3	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1, 9'		4, 918	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			6	36 1, 131 0 0		2.00 3.00 4.00
4.00 5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation				0		4.00 5.00 6.00 7.00
8.00 9.00 10.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						8.00 9.00 10.00
11.00 12.00 13.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						11.00 12.00 13.00
14. 00 15. 00	Total (see instructions) CAH visits	0.00	0	1, 9'		4, 918	15.00
16.00 17.00 18.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	0. 00 0. 00 0. 00	0	2	0 0 12 0 0	0 263 0	16.00 17.00 18.00
19.00 20.00 21.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0			0	19.00 20.00 21.00
22.00 23.00 24.00	HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE						22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC						24. 10 25. 00 26. 00
26. 25 27. 00 28. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0. 00 0. 00					26.25 27.00 28.00
29.00 30.00 31.00 32.00	Ambulance Trips Employee discount days (see instruction) Employee discount days – IRF Labor & delivery days (see instructions)						29.00 30.00 31.00 32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

PI T <i>i</i>	AL WAGE INDEX INFORMATION			Provider C	F	Period: From 07/01/2017 To 06/30/2018		pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							
o	Total salaries (see	200.00	45, 360, 326	-14, 086	45, 346, 240	0 1, 852, 140. 00	24. 48	1.
0	instructions) Non-physician anesthetist Part		C	0		0.00	0.00	2.
	A			-				
0	Non-physician anesthetist Part		C	0	(0.00	0.00	3
0	Physician-Part A -		91, 526	0	91, 526	544.00	168. 25	4
1	Administrative Physicians - Part A - Teaching		C	0		0.00	0.00	4
	Physician and Non		C	-				
	Physician-Part B							
0	Non-physician-Part B for hospital-based RHC and FQHC		C	0	(0.00	0.00	6
	servi ces		_	_				
0	Interns & residents (in an approved program)	21.00	C	0	(0.00	0.00	7
1	Contracted interns and		C	0		0.00	0.00	7
	residents (in an approved							
0	programs) Home office and/or related		C	0		0.00	0.00	8
	organization personnel		-					
-	SNF Excluded area salaries (see	44.00	C 8, 210, 459	0 284, 463	(8, 494, 922	0.00 2 470,517.00		
	instructions)		0,210,439	204, 403	0, 474, 722	470, 517.00	18.05	
	OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient Care		9, 281, 103	0	9, 281, 103	3 211, 419. 00	43.90	11
00	Contract Labor: Top Level		C	0	(0.00	0.00	12
	management and other management and administrative							
	servi ces							
00	Contract Labor: Physician-Part		252, 075	0	252, 075	5 1, 681. 00	149. 96	13
00	A - Administrative Home office and/or related		C	0		0.00	0.00	14
	organization salaries and		-					
	wage-related costs Home office salaries		C	0		0.00	0.00	11
	Related organization salaries		C	-		0.00		
00	Home office: Physician Part A		C	0	(0.00	0.00	15
00	- Administrative Home office and Contract		C	0		0.00	0.00	16
	Physicians Part A - Teaching						0.00	
	WAGE-RELATED COSTS Wage-related costs (core) (see		15,006,532	0	15, 006, 532		1	 17
00	instructions)		15,000,552		15,000,552	2		
00	Wage-related costs (other)		C	0	(0		18
00	(see instructions) Excluded areas		3, 467, 901	0	3, 467, 901			19
	Non-physician anesthetist Part		C	0	(0		20
00	A Non-physician anesthetist Part		C	0				21
	В		-					
00	Physician Part A - Administrative		32, 244	0	32, 244	ł		22
01	Physician Part A - Teaching		C	0		þ		22
	Physician Part B		C	-	(23
	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	-				24 25
	approved program)		C C					
50	Home office wage-related (core)		C	0	(D		25
51	Related organization		C	0		b		25
	wage-related (core)		-					
52	Home office: Physician Part A - Administrative -		C	0		ןנ		25
	wage-related (core)							
53	Home office & Contract		C	0	(D		25
	Physicians Part A - Teaching - wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE			1	г. Г.	1	1	1
00	Employee Benefits Department	4.00	1, 020, 052	423	1, 020, 475	31, 591. 00	32.30	26

Heal th	Financial Systems		MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 07/01/2017 Fo 06/30/2018	Worksheet S-3 Part II Date/Time Pre 11/26/2018 2:	
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
	1	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1, 936, 768	0	1, 936, 76	3 14, 886. 00	130. 11	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	603, 322	-28, 114	575, 20	3 32, 331. 00	17.79	30.00
31.00	Laundry & Linen Service	8.00	0	0	(0.00	0.00	31.00
32.00	Housekeepi ng	9.00	0	0	(0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1, 417, 727	0	1, 417, 72	7 102, 259. 00	13.86	33.00
34.00	Dietary	10.00	0	0	(0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		277, 189	0	277, 18	21, 187. 00	13.08	35.00
36.00	Cafeteria	11.00	0	0	(0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 273, 884	-398, 840	875, 04	19, 778. 00	44.24	38.00
39.00	Central Services and Supply	14.00	100, 215		109, 06	6, 659. 00	16.38	39.00
40.00	Pharmacy	15.00	2, 549, 837	0	2, 549, 83	67, 596. 00	37.72	40.00
41.00	Medi cal Records & Medi cal Records Library	16. 00	0	0		0.00	0. 00	41.00
42.00	Social Service	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0.00		43.00

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period:	Worksheet S-3	
						From 07/01/2017 To 06/30/2018		narod
						10 00/ 30/ 2010	11/26/2018 2:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.		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		48, 992, 010	-14, 086	48, 977, 92	4 1, 990, 472. 00	24. 61	1.00
	instructions)							
2.00	Excluded area salaries (see		8, 210, 459	284, 463	8, 494, 92	2 470, 517. 00	18. 05	2.00
	instructions)							
3.00	Subtotal salaries (line 1		40, 781, 551	-298, 549	40, 483, 00	2 1, 519, 955. 00	26.63	3.00
4 00	minus line 2)		0 500 470		0 500 47	0 010 100 00		4 00
4.00	Subtotal other wages & related		9, 533, 178	0	9, 533, 17	8 213, 100. 00	44.74	4.00
F 00	costs (see inst.)		45 000 77/		45 000 77		07.45	F 00
5.00	Subtotal wage-related costs		15, 038, 776	0	15, 038, 77	6 0.00	37. 15	5.00
(00	(see inst.)		65, 353, 505	200 540	65, 054, 95	(1 722 OFF 00	37. 54	6,00
6.00	Total (sum of lines 3 thru 5)							
7.00	Total overhead cost (see		17, 528, 625	-620, 748	16, 907, 87	7 642, 893.00	26.30	7.00
	instructions)			I		1		

	Financial Systems	MARION GENERAL				In Lie	eu of Form CMS-2	2552-1
HOSPI T	AL WAGE RELATED COSTS		Provi der	CCN:	15-0011	Period: From 07/01/2017	Worksheet S-3	
						To 06/30/2018		pared.
						10 00/00/2010	11/26/2018 2:	
							Amount	
							Reported	
							1.00	
	PART IV - WAGE RELATED COSTS							-
	Part A - Core List RETIREMENT COST							-
1 00	401K Employer Contributions						1, 172, 303	1.0
1.00 2.00	Tax Sheltered Annuity (TSA) Employer Contril	oution					1, 172, 303	
2.00	Nongualified Defined Benefit Plan Cost (see						4, 160, 544	
4.00	Qualified Defined Benefit Plan Cost (see in:						4, 100, 544	
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External						1 0	4.0
5.00	401K/TSA PI an Admini strati on fees						0	5.0
6.00	Legal /Accounting/Management Fees-Pension Pla	an					134, 321	6.0
7.00	Employee Managed Care Program Administration						0	
	HEALTH AND INSURANCE COST							1
8.00	Health Insurance (Purchased or Self Funded)						0	8.0
8.01	Health Insurance (Self Funded without a Thin	rd Party Administra	tor)				0	
8.02	Health Insurance (Self Funded with a Third I						8, 047, 137	
8.03	Health Insurance (Purchased)	, , , , , , , , , , , , , , , , , , ,	,				0	
9.00	Prescription Drug Plan						0	9.0
10.00	Dental, Hearing and Vision Plan						0	10.0
11.00	Life Insurance (If employee is owner or bend	efi ci ary)					0	11.0
12.00	Accident Insurance (If employee is owner or	beneficiary)					0	12.0
13.00	Disability Insurance (If employee is owner of	or beneficiary)					321, 975	13.0
14.00	Long-Term Care Insurance (If employee is own	ner or beneficiary)					0	14.0
15.00	'Workers' Compensation Insurance						389, 558	15.0
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	ordinary a	ccrua	al require	ed by FASB 106.	0	16.0
	Non cumulative portion)							
	TAXES							
	FICA-Employers Portion Only						3, 990, 055	
	Medicare Taxes - Employers Portion Only						0	
19.00	Unemployment Insurance						3, 265	
20.00	State or Federal Unemployment Taxes OTHER						0	20.0
21 00		Dati noment Coat De	norted on	Line	0.1 + 6 - 00	10h 1 abova (000	0	21.0
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost Re	eported on	TINE	es i throu	ign 4 above. (see	0	21.0
22 00	Day Care Cost and Allowances						0	22.0
	Tuition Reimbursement						287, 519	
	Total Wage Related cost (Sum of lines 1 -23))					18, 506, 677	
2 1.00	Part B - Other than Core Related Cost	/					10, 300, 077	27.0
	OTHER WAGE RELATED COSTS (SPECIFY)							25.0

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0011	Peri od:	Worksheet S-3	
				From 07/01/2017		
				To 06/30/2018	Date/Time Pre 11/26/2018 2:	
	Cost Center Description			Contract Labor	Benefit Cost	
	best benter bescription			1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identif	fication:				
1.00	Total facility's contract labor and benefit of	cost		9, 281, 103	18, 506, 677	1.00
2.00	Hospi tal			9, 281, 103	18, 506, 677	2.00
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems MARION GENERAL H	HOSPI TAL		In Li€	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0011	Peri od:	Worksheet S-1	0
				From 07/01/2017 To 06/30/2018		
					11/26/2018 2:	<u>38 pm</u>
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 columr	n 8)	0. 260215	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				20, 611, 022	•
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ni d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	d		0	5.00
6.00 7.00	Medicaid charges				88, 859, 306 23, 122, 524	
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	(lino 7 min	us sum of lir	oc 2 and 5: if	23, 122, 524	
8.00	<pre>< zero then enter zero)</pre>			ies z and 5, TT	2, 511, 502	0.00
	Children's Health Insurance Program (CHIP) (see instructions f	or each line	e)			
9.00	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi)	nus line 9; i	f < zero then	0	12.00
	enter zero)	+				-
13.00	Other state or local government indigent care program (see ins Net revenue from state or local indigent care program (Not inc				0	13.00
14.00	Charges for patients covered under state or local indigent car				0	
14.00			Not The dded		0	14.00
15.00	State or local indigent care program cost (line 1 times line 1	4)			0	15.00
16.00	Difference between net revenue and costs for state or local in	digent care	program (lir	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state	e/local indig	jent care prograi	ms (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to f	Fundi na chari	ity caro		0	17.00
	Government grants, appropriations or transfers for support of				0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and Loca			(sum of lines	2, 511, 502	
	8, 12 and 16)		cure program		2,011,002	17.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fa	cility	3, 803, 59	3, 313, 981	7, 117, 575	20.00
20100	(see instructions)	.orreg	0,000,0	0,010,701	,,,.,.	20.00
21.00	Cost of patients approved for charity care and uninsured disco	ounts (see	989, 7	52 3, 313, 981	4, 303, 733	21.00
	instructions)					
22.00	Payments received from patients for amounts previously written	n off as	1, 14	13 502	1, 645	22.00
23.00	charity care Cost of charity care (line 21 minus line 22)		988, 60	3, 313, 479	4, 302, 088	23.00
		1				
	1				1.00	
24.00	Does the amount on line 20 column 2, include charges for patie		ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t		care program	's length of	0	25.00
	stay limit				_	
26.00	Total bad debt expense for the entire hospital complex (see in	nstructions)			7, 710, 715	26.00
27.00	Medicare reimbursable bad debts for the entire hospital comple	ex (see insti	ructions)		744, 404	27.00
	Medicare allowable bad debts for the entire hospital complex (see instruc	tions)		1, 145, 237	•
	Non-Medicare bad debt expense (see instructions)				6, 565, 478	
	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see i	instructions)		2, 109, 269	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	i			6, 411, 357	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			8, 922, 859	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARION GENERAL F EXPENSES	<u>HOSPITAL</u>	CN: 15-0011 P	In Lie Veriod:	u of Form CMS-: Worksheet A	2552-10
				F	rom 07/01/2017 o 06/30/2018	Date/Time Pre 11/26/2018 2:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		12 (2) 047	12 (2) 047	1 000 505	10 500 050	1 1 00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 020, 052	13, 626, 947 17, 371, 409	13, 626, 947 18, 391, 461		12, 588, 352 18, 427, 221	
5.00	00500 ADMI NI STRATI VE & GENERAL	8, 349, 631	23, 787, 621	32, 137, 252		32, 043, 859	1
6.00	00600 MAINTENANCE & REPAIRS	0	0	C	0	0	
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A	0	0	C	1, 287, 711 0	1, 287, 711 0	1
7.00	00700 OPERATION OF PLANT	603, 322	4, 356, 771	4, 960, 093		5, 378, 730	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	2 024 222	427, 968	427, 968	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	3, 024, 222 1, 835, 351	3, 024, 222 1, 835, 351		2, 606, 388 514, 639	
13.00	01300 NURSING ADMINISTRATION	1, 273, 884	86, 851	1, 360, 735	-398, 840	961, 895	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	100, 215 2, 549, 837	270, 242 9, 190, 386	370, 457 11, 740, 223		379, 311	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	2, 549, 837	9, 190, 386	11, 740, 223	-8, 425, 650	3, 314, 573	15.00
30.00	03000 ADULTS & PEDI ATRI CS	6, 970, 465	1, 412, 950	8, 383, 415		7, 625, 874	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	1, 896, 041	714, 012	2, 610, 053	5, 506	2, 615, 559 0	1
40.00	04100 SUBPROVIDER - IRF	939, 836	730, 058	1, 669, 894	0	1, 669, 894	1
42.00	04200 SUBPROVI DER	0	0	C	-	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	C	1, 006, 852	1, 006, 852	43.00
50.00	05000 OPERATI NG ROOM	0	13, 234, 562	13, 234, 562	167, 466	13, 402, 028	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	2, 935, 120	2, 891, 901	5, 827, 021	-1, 065, 255 1, 011, 419	4, 761, 766 1, 011, 419	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	505, 750	505, 750	1
59.00	05900 CARDI AC CATHETERI ZATI ON	580, 636	1, 296, 242	1, 876, 878		1, 912, 553	
60. 00 60. 01	06000 LABORATORY 06001 0NC0L0GY	2, 230, 977 943, 033	5, 835, 235 608, 473	8, 066, 212 1, 551, 506		8, 066, 781 1, 551, 506	
60. 02	06002 RADIATION ONCOLOGY	0	0	1, 001, 000		0	1
65.00		1, 258, 173	738, 749	1, 996, 922		2, 010, 390	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	1, 524, 713 710, 819	320, 681 183, 641	1, 845, 394 894, 460		1, 845, 394 984, 759	
69. 01	06901 CARDI AC REHAB	124, 410	22, 205	146, 615		184, 688	1
71.00 72.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0	C	-	0	
72.00	07200 TMPL. DEV. CHARGED TO PATTENTS 07300 DRUGS CHARGED TO PATTENTS	0	0		-	8, 425, 650	1
	OUTPATIENT SERVICE COST CENTERS						
90.00 91.00	09000 CLINIC 09100 EMERGENCY	280, 047 3, 798, 492	244, 805 1, 298, 392	524, 852 5, 096, 884		556, 076 5, 042, 202	1
		3, 770, 472	1, 270, 372	3, 070, 004	54, 002	5, 042, 202	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C	0	0	92.01
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1, 016, 107	175, 537	1, 191, 644	54, 682	1, 246, 326	95.00
70.00	SPECIAL PURPOSE COST CENTERS	1,010,107	170,007	1, 171, 011	01,002	1, 210, 020	/0.00
	11300 INTEREST EXPENSE	20 105 010	0		-		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	39, 105, 810	103, 257, 243	142, 363, 053	-6, 939	142, 356, 114	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 552	19, 552			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS	0	0	C	0		192.00 192.02
	19203 GREAT BEGINNINGS/MATERNAL	85, 260	16, 167	101, 427	9, 937	111, 364	
	19204 LI FELI NE	0	0	C	0		192.04
	19205 OWNED PROPERTIES 19206 UROLOGY	0 322, 463	1, 229, 458 1, 118, 210	1, 229, 458 1, 440, 673		83, 802 1, 495, 050	192.05
	19211 PARI SH NURSI NG	27, 804	15, 281	43, 085			192.08
	19212 BIOTERRORI SM GRANT	0	9, 039	9, 039			192.09
	19214 BREAST PUMPS 19209 LUNG CENTER	0 109, 709	0 563, 789	C 673, 498	0 27, 837	0 701, 335	192.10 192.12
192.14	19210 MGH PHYS PRACT MGMT	944, 691	547, 074	1, 491, 765	42, 418	1, 534, 183	192. 14
	19215 MGH MARION SURGEONS	490, 811 0	1, 915, 176	2, 405, 987		2, 477, 697	
	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	0 730, 386	1, 428, 834 2, 374, 525	1, 428, 834 3, 104, 911	-	1, 428, 834 3, 461, 209	
192.18	19218 MGH FAIRM MED ASSOC	94, 677	265, 062	359, 739	307	360, 046	192. 18
	19219 MGH FMC MARION	254, 955 0	499, 584	754, 539 0		792, 094	
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD	0 312, 388	0 999, 033	1, 311, 421	0 616	0 1, 312, 037	193.00 193.01
193.02	19302 MGH FMC GAS CITY	219, 170	637, 603	856, 773	105, 148	961, 921	193. 02
	19303 MGH HOSPITALISTS 19304 MGH MAR FAM PRACT	35, 105 900, 711	3, 980, 179 2, 061, 417	4,015,284		4,015,284	
	19304 MGH MAR FAM PRACT 19305 MGH FMC SWAYZEE	73, 188	2, 061, 417 164, 770	2, 962, 128 237, 958		2, 962, 128 286, 233	
	i I	-,		,			

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	Provider CC		Period:	Worksheet A	
				From 07/01/2017 To 06/30/2018	Date/Time Pre	pared:
					11/26/2018 2:	38 pm
Cost Center Description	Sal ari es	Other	Total (col. 1			
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
193.06 19306 MGH PEDIATRIC CTR	231, 079	926, 333				
193.07 19307 MGH SPECIALTY PHYS	77, 163	251, 545				
193.08 19308 MGH FMC CONVERSE	101, 422	241, 693	343, 115	5 307	343, 422	193.08
193.09 19309 MGH UPLAND HEALTH	407, 734	1, 279, 632	1, 687, 366	6, 314	1, 693, 680	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		193. 11
193. 12 19312 OB/GYN	503, 419	2, 181, 732	2, 685, 151	4, 928	2, 690, 079	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	(0 0	0	193. 15
194.0007963 HEART FAILURE CLINIC	0	27, 069	27, 069	9 0	27,069	194.00
194.0107950 MOW	0	0	(0 0	0	194.01
194.0207951 MENTAL HEALTH	0	0	(0 0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	(259, 241	259, 241	194.03
194.04 07953 MGH WORK SOLUTIONS	287, 742	507,019	794, 76	49, 531	844, 292	194.04
194.0507954 MGH TAYLOR UNIVERSITY	28, 811	107, 219	136, 030		136, 030	194.05
194.0807957 MGH SMMP BLDG	0	313, 743	313, 743	-67, 813	245, 930	194.08
194.0907958 MGH AMBUCARE BLDG	0	0	(0		194.09
194.1007959 MGH 106 LYONS BLDG	0	6,069	6,069	9 0	6,069	194.10
194. 11 07960 FAI RMOUNT	0	24, 470			24, 470	
194. 12 07961 GAS_CLTY	0	,0	,	0		194.12
194. 13 07962 LYONS	0	0	(0		194.13
194. 14 07964 WABASH	0	1, 650	1, 650	0		194.14
194. 15 07965 TOBACCO GRANT	15, 828	17,075				
200.00 TOTAL (SUM OF LINES 118 through 199)	45, 360, 326	126, 987, 245			172, 347, 571	
				1 1		

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARION GENERA F EXPENSES	AL HOSPITAL Provider CCN:	: 15-0011	In Lieu of Form Period: Worksheet From 07/01/2017 To 06/30/2018 Date/Time	: A e Prepared:
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		11/26/201	18 2:38 pm
	GENERAL SERVICE COST CENTERS	6.00	7.00			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-35, 971	12, 552, 381			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 945, 135				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-12, 543, 251				5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0			6.00
6.01	00601 CAFETERI A	-13, 371	1, 274, 340			6. 01
6.02	00602 CAFETERI A	0	0			6. 02
7.00	00700 OPERATION OF PLANT	-154, 545				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-3, 074				8.00
9.00	00900 HOUSEKEEPI NG	-3, 616				9.00
10.00		968				10.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON	0				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	-464 -40, 998				14.00 15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	-40, 990	3,213,515			15.00
30.00	03000 ADULTS & PEDI ATRI CS	-48, 154	7, 577, 720			30, 00
31.00	03100 I NTENSI VE CARE UNI T	-232				31.00
40.00	04000 SUBPROVI DER – I PF	0				40.00
41.00	04100 SUBPROVI DER – I RF	-71, 096	1, 598, 798			41.00
42.00	04200 SUBPROVI DER	0	0			42.00
43.00	04300 NURSERY	0	1, 006, 852			43.00
	ANCI LLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	-1, 143, 981				50.00
51.00	05100 RECOVERY ROOM	104 052	0			51.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	-184, 952				54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	-4, 399				59.00
60.00	06000 LABORATORY	-99, 602				60.00
60.01	06001 ONCOLOGY	-4, 918				60.01
60.02	06002 RADIATION ONCOLOGY	0	0			60.02
65.00	06500 RESPI RATORY THERAPY	-2, 817	2,007,573			65.00
66.00	06600 PHYSI CAL THERAPY	-92	1, 845, 302			66.00
69.00	06900 ELECTROCARDI OLOGY	-53, 721	931, 038			69.00
69.01	06901 CARDI AC REHAB	-7				69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8, 425, 650			73.00
90.00	OUTPATIENT SERVICE COST CENTERS	- 10, 799	545, 277			90.00
	09100 EMERGENCY	-165, 643				90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	105, 045	4,070,007			92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	О			92.01
	OTHER REIMBURSABLE COST CENTERS	-				
95.00	09500 AMBULANCE SERVI CES	-59, 639	1, 186, 687			95.00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE	0				113.00
118.00		-17, 589, 509	124, 766, 605			118.00
	NONREI MBURSABLE COST CENTERS		51.005			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51, 235			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS		0			192.00 192.02
	19203 GREAT BEGINNINGS/MATERNAL		111, 364			192.02
	19204 LI FELI NE	0	0			192.03
	19205 OWNED PROPERTIES	0	83, 802			192.05
	19206 UROLOGY	-57, 558				192.06
192.08	19211 PARI SH NURSI NG	0	52, 324			192.08
	19212 BI OTERRORI SM GRANT	0	37, 153			192.09
	19214 BREAST PUMPS	0	0			192.10
	19209 LUNG CENTER	-47,041				192.12
	19210 MGH PHYS PRACT MGMT	-66, 568				192.14
	19215 MGH MARI ON SURGEONS	-110, 484				192.15
	19216 MGH MGH MED ONC	220.062				192.16
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	-330, 963				192. 17 192. 18
	19218 MGH FAIRM MED ASSUC	-26, 464 -57, 508				192.18
	19219 MGH FMC MARION 19300 NONPALD WORKERS	-57,508	1 1			192.19
	19301 MGH FMC NORTHWOOD		1, 312, 037			193.00
	19302 MGH FMC GAS CITY	-141, 337				193.02
	19303 MGH HOSPI TALI STS	0				193.03
	19304 MGH MAR FAM PRACT	0	2, 962, 128			193.04
	19305 MGH FMC SWAYZEE	-29, 547				193.05
193.05						1
193.06	19306 MGH PEDIATRIC CTR 19307 MGH SPECIALTY PHYS	-65, 154 -24, 230				193.06 193.07

Health Financial Systems	MARION GENERA	AL HOSPI TAL	In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CCN: 15-001			
			From 07/01/2017 To 06/30/2018 Date/Time Prepared:		
			11/26/2018 2:38 pm		
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7.00			
193.08 19308 MGH FMC CONVERSE	0	343, 422	193. 08		
193.09 19309 MGH UPLAND HEALTH	0	1, 693, 680	193. 09		
193.10 19310 MGH MGH WOMENS CTR	0	0	193. 10		
193.11 19311 MGH MGH PSYCHLATRY	0	0	193. 11		
193. 12 19312 OB/GYN	0	2, 690, 079	193. 12		
193.15 19315 MGH RIVER VIEW BLDG	0	0	193. 15		
194.0007963 HEART FAILURE CLINIC	0	27, 069	194.00		
194. 01 07950 MOW	0	0	194. 01		
194.0207951MENTAL HEALTH	0	0	194. 02		
194. 03 07952 ADVERTI SI NG	0	259, 241	194. 03		
194.0407953MGH WORK SOLUTIONS	-106, 598	737, 694	194. 04		
194.0507954 MGH TAYLOR UNIVERSITY	0	136, 030	194. 05		
194.08 07957 MGH_SMMPBLDG	0	245, 930	194. 08		
194.09 07958 MGH_AMBUCARE_BLDG	0	0	194. 09		
194.10 07959 MGH 106 LYONS BLDG	0	6, 069	194. 10		
194. 11 07960 FAI RMOUNT	0	24, 470	194. 11		
194. 12 07961 GAS CI TY	0	0	194. 12		
194. 13 07962 LYONS	0	0	194. 13		
194.14 07964 WABASH	0	1, 650	194.14		
194. 15 07965 TOBACCO GRANT	0	38, 371	194. 15		
200.00 TOTAL (SUM OF LINES 118 through 199)	-18, 652, 961	153, 694, 610	200. 00		

CLAS	Financial Systems SIFICATIONS		MARION GENERAL	Provider CCN: 15		Lieu of Form CMS-2552 Worksheet A-6
					To 06/30/20	
		Increases				
	Cost Center	Line #	Salary	Other		
		3.00	4.00	5.00		
00	A - SATELLITE OFFICE RECLASS ELECTROCARDIOLOGY	69.00	11, 391	3, 627		1
00	RADI OLOGY-DI AGNOSTI C	54.00	64, 602	9, 089		2
00			75, 993	- <u> </u>		
	B - CAFETERIA RECLASS					
00	ADMI NI STRATI VE & GENERAL	5.00	0	61, 005		1
00	CAFETERI A	6.01	0	<u>1, 287, 7</u> 11		2
	0		0	1, 348, 716		
~~	C - ADMIN DIRECTOR RECLASS	4.00	400	0		1
00 00	EMPLOYEE BENEFITS DEPARTMENT	4.00 14.00	423	0 0		1
00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	30.00	8, 854 255, 239	0		2
00	CARDIAC CATHETERIZATION	59.00	35, 675	0		4
00	RESPIRATORY THERAPY	65.00	13, 468	0		5
00	ELECTROCARDI OLOGY	69.00	59, 459	0		6
00	CARDI AC REHAB	69.01	23, 784	0		7
00	AMBULANCE SERVICES	95.00	54, 682	0		8
00	GIFT, FLOWER, COFFEE SHOP &	190.00	31, 683	0		9
	CANTEEN					
. 00	GREAT BEGI NNI NGS/MATERNAL	192.03	9, 937	0		10
. 00	PARI SH NURSI NG	192.08	5, 468	0		11
. 00	BI OTERRORI SM GRANT	192.09	28, 114	0		12
. 00	TOBACCO GRANT	1 <u>94.</u> 15	5, 468	0		13
			532, 254	0		
00	D - ADVERTISING	104 02	140 111	00 120		1
00	ADVERTISING	1 <u>94.</u> 03	<u>169, 1</u> 11 169, 111	9 <u>0, 130</u> 90, 130		1
	E - LEASED PROPERTY		107, 111	70, 130		
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35, 337		1
00	ADMI NI STRATI VE & GENERAL	5.00	0	120, 144		2
00	OPERATION OF PLANT	7.00	0	445, 214		3
00	HOUSEKEEPING	9.00	0	9, 796		4
00	DI ETARY	10.00	0	27, 435		5
00	OPERATING ROOM	50.00	0	167, 466		6
00	RADI OLOGY-DI AGNOSTI C	54.00	0	308, 004		7
00	CT SCAN	57.00	0	21, 629		8
00	MAGNETIC RESONANCE IMAGING	58.00	0	24, 391		9
	(MRI)					
. 00	LABORATORY	60.00	0	86, 629		10
00	ELECTROCARDI OLOGY	69.00	0	15, 822		11
00	CARDIAC REHAB	69.01	0	14, 289		12
00	CLINIC	90.00	0	31, 224		13
	PARI SH NURSI NG	192.08	0	3, 771		14
	LUNG CENTER	192.12	0	27,837		15
	MGH PHYS PRACT MGMT	192.14	0	42, 418		16
. 00	MGH MARION SURGEONS	192.15	0	71, 710		17
00	MGH FMC SOUTH MGH FAIRM MED ASSOC	192.17 192.18	0	352, 672		18
00		192. 18 192. 19	0	307 37, 555		20
	MGH FMC MARION		0			
00 00	MGH WORK SOLUTIONS	194.04 192.06	0	49, 531 54, 377		21
00	MGH FMC NORTHWOOD	192.08	0	616		22
00	MGH FMC GAS CITY	193.01	0	105, 148		23
00	MGH FMC GAS CITY MGH FMC SWAYZEE	193.02	0	48, 275		24
00	MGH PEDIATRIC CTR	193.05	0	40, 275		25
00	MGH SPECIALTY PHYS	193.00	0	14, 035		20
00	MGH FMC CONVERSE	193.07	0	307		28
00	MGH UPLAND HEALTH	193.09	o	6, 314		29
00	OB/GYN	193.12	0	4, 928		30
	0	<u> </u>	0	2, 184, 251		
	F - PHARMACY RECLASS					
00	DRUGS_CHARGED_TO_PATIENTS	73.00	0	<u>8, 425, 6</u> 50		1
	0		0	8, 425, 650		
	G - CT/MRI RECLASS	!		400 10-		
00	CT SCAN	57.00	497, 824	490, 495		1
00	MAGNETIC RESONANCE I MAGI NG	58.00	241, 631	238, 072		2
	(<u>MRI</u>)	+				
	0 H - SHORT TERM DISABILITY RECL	ΔSS	739, 455	728, 567		
00	ADMINISTRATIVE & GENERAL	ASS 5.00	0	3, 764		1
00	INTENSIVE CARE UNIT	31.00	0	3, 764 5, 928		2
00	RADI OLOGY-DI AGNOSTI C	54.00	0	5, 928		3
	LABORATORY	60.00	0	1, 072		4
00		00.00	VI	1,014		1 4

Heal th	Financial Systems		MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provider C	CCN: 15-0011	Peri od:	Worksheet A-	6
						From 07/01/2017 To 06/30/2018	Date/Time Prepared: 11/26/2018 2:38 pm	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	0		0	14, 086				
	I – NURSERY RECLASS							
1.00	NURSERY	43.00	<u>881, 1</u> 75	12 <u>5, 6</u> 77				1.00
	0		881, 175	125, 677				
	J - SMMP HOUSEKEEPING RECLASS							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	14, 895				1.00
2.00	OPERATION OF PLANT	7.00	0	1, 537				2.00
3.00	HOUSEKEEPI NG	9.00	0	338				3.00
4.00	DI ETARY	10.00	0	569				4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	21, 072				5.00
6.00	CT SCAN	57.00	0	1, 471				6.00
7.00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 656				7.00
	(MRI)							
8.00	LABORATORY	60.00	0	2, 649				8.00
9.00	MGH_FMC_SOUTH	192. 17	0	2 <u>3, 6</u> 26				9.00
	0		0	67, 813				
	K - LAUNDRY RECLASS							
1.00	LAUNDRY & LINEN SERVICE	8.00	0	427, 968				1.00
	0		0	427, 968				
	L - PHYSICIAN MEDICAL DIRECTO	R RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	20, 000	0				1.00
	0		20, 000	0				
500.00	Grand Total: Increases		2, 417, 988	13, 425, 574				500.00

	Financial Systems SIFICATIONS		MARION GENERA		CCN: 15-0011	Period: From 07/01/2017	u of Form CMS-2552-10 Worksheet A-6
					1	To 06/30/2018	Date/Time Prepared: 11/26/2018 2:38 pm
	Cost Center	Decreases Line #	Salary	Other	 Wkst. A-7 Ref	.	
	6.00	7.00	8.00	9.00	10.00	·	
	A - SATELLITE OFFICE RECLASS	(0.00	11.001		-		1.00
1.00 2.00	LABORATORY LABORATORY	60.00 60.00	11, 391 64, 602	3, 627 9, 089		0	1.00
	0		75, 993	12, 716			2.00
	B - CAFETERIA RECLASS						
1.00 2.00	DI ETARY	10.00 0.00	0	1, 348, 716 (0	1.00
	0		0	1, 348, 716			
	C - ADMIN DIRECTOR RECLASS	5.00	50.10/				1.00
1.00 2.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	50, 196 28, 114	(0	1.00
3.00	NURSING ADMINISTRATION	13.00	398, 840	C		0	3.00
1.00	INTENSIVE CARE UNIT	31.00	422	0		0	4.00
5.00 5.00	EMERGENCY	91.00 0.00	54, 682 0	0		0	5.00
7.00		0.00	Ō	C		0	7.00
3.00		0.00	0	0		0	8.00
9.00 10.00		0.00 0.00	0	(0	9.00 10.00
1.00		0.00	0	C		0	11.00
2.00		0.00	0	0		0	12.00
3.00	<u> </u>		532, 254	0		<u>o</u>	13.00
	D - ADVERTISING		002/201		· [
. 00	ADMI NI STRATI VE & GENERAL		- 169, 111	9 <u>0, 1</u> 30		Q	1.00
	E - LEASED PROPERTY		169, 111	90, 130	J		
I. 00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 038, 595	5 1	0	1.00
2.00	FIXT OWNED PROPERTIES	192.05	o	1, 145, 656		0	2.00
3.00	owned ThoreRTTES	0.00	0	1, 143, 030		0	3.00
1.00		0.00	0	C		0	4.00
5.00 5.00		0.00 0.00	0	(0	5.00
7.00		0.00	0	C		0	7.00
3.00		0.00	0	0		0	8.00
9.00 10.00		0.00 0.00	0	0		0	9.00 10.00
1.00		0.00	0	C		0	11.00
2.00		0.00	0	0		0	12.00
3.00 4.00		0.00 0.00	0	0		0	13.00 14.00
5.00		0.00	Ő	C		0	15.00
6.00		0.00	0	0		0	16.00
17.00 18.00		0.00 0.00	0	(0	17.00 18.00
9.00		0.00	0	C		0	19.00
20.00		0.00	0	(0	20.00
21.00 22.00		0.00 0.00	o	(0	21.00 22.00
23.00		0.00	О	C		0	23.00
24.00 25.00		0.00 0.00	0	(0	24.00 25.00
26.00		0.00	0	(0	25.00
27.00		0.00	О	C		0	27.00
28.00		0.00 0.00	0	0		0	28.00 29.00
29.00 30.00		0.00	0	(ó	0	30.00
			0	2, 184, 251		7	
I. 00	F - PHARMACY RECLASS PHARMACY	15.00	0	8, 425, 650		0	1.00
	0			8, 425, 650		1	
	G - CT/MRI RECLASS		700 155		1		
1.00 2.00	RADI OLOGY-DI AGNOSTI C	54.00 0.00	739, 455 0	728, 567 (0	1.00
	<u> </u>	0.00	739, 455	728, 567		<u> </u>	2.00
	H - SHORT TERM DI SABI LI TY REC				1	त	
. 00 2. 00	ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	5.00 30.00	3, 764 5, 928	(0	1.00
. 00 . 00	RADI OLOGY-DI AGNOSTI C	30.00 54.00	5, 928	(0	3.00
1.00	LABORATORY	60.00	1, 072	C		0	4.00
F. 00 5. 00	EMERGENCY	91.00	3, 298	(5.00

Heal th	Financial Systems		MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2552-1
	SIFICATIONS			Provider (CCN: 15-0011	Peri od:	Worksheet A-6
						From 07/01/2017 To 06/30/2018	Date/Time Prepared: 11/26/2018 2:38 pm
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .	
	6. 00	7.00	8.00	9.00	10.00		
	I – NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS		<u>881, 1</u> 75	12 <u>5, 6</u> 77		Q	1.00
	0		881, 175	125, 677			
	J - SMMP HOUSEKEEPING RECLASS	5					
1.00	MGH SMMP BLDG	194.08	0	67, 813		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
5.00		0.00	o	0		0	5.00
6.00		0.00	o	0		0	6.00
7.00		0.00	0	0)	0	7.00
8.00		0.00	0	0)	0	8.00
9.00		0.00	o	0		0	9.00
	<u> </u>		o	67,813		1	
	K - LAUNDRY RECLASS	· · · · ·				- 1	
1.00	HOUSEKEEPI NG	9.00	0	427, 968		0	1.00
	<u> </u>			427, 968		1	
	L - PHYSICIAN MEDICAL DIRECTO	R RECLASS					
1.00	MGH FMC SOUTH	192.17	20,000	0		0	1.00
	<u> </u>	+	20,000	0		1	
500.00	Grand Total: Decreases		2, 432, 074	13, 411, 488		-	500.00
		· · ·			1	1	1

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0011	Period: From 07/01/2017 To 06/30/2018		
			Acqui si ti on	IS		
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASS	ET BALANCES		_		_	
1.00 Land	4, 646, 549	0		0 0	0	1.00
2.00 Land Improvements	3, 353, 531	0		0 0	0	2.00
3.00 Buildings and Fixtures	122, 368, 873	10, 003, 796		0 10, 003, 796	16, 947	3.00
4.00 Building Improvements	3, 287, 381	0		0 0	0	4.00
5.00 Fixed Equipment	1, 144, 744	2, 044, 832		0 2, 044, 832	13, 141	5.00
6.00 Movable Equipment	79, 662, 007	12, 667, 724		0 12, 667, 724	15, 799, 005	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	214, 463, 085	24, 716, 352		0 24, 716, 352	15, 829, 093	8.00
9.00 Reconciling Items	0	0		0 0	0	•
10.00 Total (line 8 minus line 9)	214, 463, 085	24, 716, 352		0 24, 716, 352	15, 829, 093	10.00
	Endi ng Bal ance					
		Depreciated				
		Assets				
	6.00	7.00	1			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASS	ET BALANCES					
1.00 Land	4, 646, 549	0				1.00
2.00 Land Improvements	3, 353, 531	0				2.00
3.00 Buildings and Fixtures	132, 355, 722	0				3.00
4.00 Building Improvements	3, 287, 381	0				4.00
5.00 Fixed Equipment	3, 176, 435	0				5.00
6.00 Movable Equipment	76, 530, 726	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	223, 350, 344	0				8.00
9.00 Reconciling Items	0	l o				9.00
10.00 Total (line 8 minus line 9)	223, 350, 344	0				10.00
		-	1			

Heal th	Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0011	Period: From 07/01/2017 To 06/30/2018		pared:
			SU	JMMARY OF CAP	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	13, 626, 947	0		0 0	0	1.00
3.00	Total (sum of lines 1-2)	13, 626, 947	0		0 0	0	3.00
	SUMMARY OF CAPITAL						
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13, 626, 947				1.00
3.00	Total (sum of lines 1-2)	0	13, 626, 947				3.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 07/01/2017 To 06/30/2018	Worksheet A-7 Part III Date/Time Pre 11/26/2018 2:3	pared:
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	223, 350, 344	0	223, 350, 344	1.000000	0	1.00
3.00 Total (sum of lines 1-2)	223, 350, 344		223, 350, 344			3.00
		TION OF OTHER (F CAPITAL	3.00
	, NELCON	IT ON OF OTHER (i on the	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	-	1	1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(1.00
3.00 Total (sum of lines 1-2)	0	°	(13, 626, 947	-1, 038, 595	3.00
		SL	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
					10 550 001	1 00
1.00 NEW CAP REL COSTS-BLDG & FLXT 3.00 Total (sum of lines 1-2)	-35, 971					1.00 3.00
3.00 Total (sum of lines 1-2)	-35, 971	0	l (0 0	12, 552, 381	3.00

	Financial Systems MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 07/01/2017 To 06/30/2018	Date/Time Prep 11/26/2018 2:3	
				Expense Classification or To/From Which the Amount is			<u>30 pm</u>
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		C	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1. C
00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	*** Cost Center Deleted ***	2.00	0	2.0
00	Investment income - other		C		0.00	О	3. (
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4. (
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5. (
00	expenses (chapter 8) Rental of provider space by		C		0.00	0	6. (
00	suppliers (chapter 8) Telephone services (pay		-		0.00		7.0
50	stations excluded) (chapter 21)				0.00	0	7.1
00	Television and radio service (chapter 21)		C		0.00		
00 . 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	-1, 536, 038		0.00	0	9. (10. (
. 00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
. 00	Related organization transactions (chapter 10)	A-8-1	C			0	12.
	Laundry and linen service	P	0 410		0. 00 6. 01		
	Cafeteria-employees and guests Rental of quarters to employee and others	В	-9, 410 C	CAFETERI A	0.00	0	
00	Sale of medical and surgical supplies to other than		C		0.00	0	16.
00	patients Sale of drugs to other than		C		0.00	0	17.
00	patients Sale of medical records and		C		0.00	0	18.
00	abstracts Nursing and allied health education (tuition, fees,		C		0.00	0	19.
00	books, etc.) Vending machines		C		0.00	0	20.
	Income from imposition of interest, finance or penalty		C		0.00		
00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.
. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
	therapy costs in excess of limitation (chapter 14)						
. 00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.
00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.
. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	FIXT *** Cost Center Deleted ***	2.00	0	27.
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.
	Physicians' assistant Adjustment for occupational	A-8-3	C	*** Cost Center Deleted ***	0.00 67.00		29. 30.
	therapy costs in excess of limitation (chapter 14)				07.00		
. 99	Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30.
. 00	Adjustment for speech pathology costs in excess of	A-8-3	C	*** Cost Center Deleted ***	68.00		31.
00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.
. 00	Depreciation and Interest		C		0.00	U	JZ.

Heal th	Financial Systems		MARION GENERA	AL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0011	Period: From 07/01/2017	Worksheet A-8	
					To 06/30/2018	Date/Time Prep	
				Expense Classification of	n Worksheet A	11/26/2018 2:3	38 pm
				To/From Which the Amount i			
					,		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.00	RETURNED CHECK FEE	B		3.00 ADMI NI STRATI VE & GENERAL	4.00		33.00
	PHYSICIAN PRIV APPLIC	В		ADMI NI STRATI VE & GENERAL	5.00		
33.02	SALE OF MEDICAL RECORDS &	В	-56, 456	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33. 03	ABSTRACTS CHILD SEAT SAFETY INSPECTION	В	-2 340	ADMI NI STRATI VE & GENERAL	5.00	0	33.03
	HEALTH SCREENING FEES - LAB	B		LABORATORY	60.00		
	HEALTH SCREENING FEES - RAD	В		RADI OLOGY-DI AGNOSTI C	54.00		
33.06	MED STAFF OTHER SCREENING-MED STAFF	В	1, 450	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07	HEALTH SCREENING FEES	В	-4, 231	LABORATORY	60.00	о	33.07
33.08	REBATE	В	-92, 912	ADMI NI STRATI VE & GENERAL	5.00		33.08
33.09	RENTAL OF PROVIDER SPACE BY	В	-1, 200	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33. 10	SUPPLIER RENT SPACE UPLAND	В	-19.691	LABORATORY	60.00	0	33.10
33. 11	PAGER RENTAL	В		ADMI NI STRATI VE & GENERAL	5.00		
	SALE OF SCRAP, WASTE, ETC,	В		ADMINI STRATI VE & GENERAL	5.00		
	PCC MARKETING AG EDUCATIONAL WORKSHOP	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00		
	OPT HEALTH LINEN SEV	B		LAUNDRY & LINEN SERVICE	8.00		
	AMBULANCE SVC - ASSISTS	В		AMBULANCE SERVICES	95.00		
	AMBULANCE SVC - CORONER SVC AMBULANCE SVC - LINEN SERVICES	B B		AMBULANCE SERVICES AMBULANCE SERVICES	95.00 95.00		33. 17 33. 18
	AMBULANCE SVC - COMMUNITY	B		AMBULANCE SERVICES	95.00		
	EVENT STAF						
33.20	CONTRACT ARU OTH ARU MEDICAL	В	-59, 825	SUBPROVIDER – IRF	41.00	0	33.20
33. 21	SCHOOL PHYS OTH SCHOOL PHYS	В	-13,460	ADMI NI STRATI VE & GENERAL	5.00	о	33. 21
33. 22	CLINICAL STUDY- OTHER	В	-3, 960	ONCOLOGY	60. 01	0	33. 22
	SICK CHILD CARE PROGRAM	В		ADULTS & PEDIATRICS	30.00		
	ONC. QUAL SETTLEMENTS	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00		
33.26	UNCLAIMED OTHER 125 MED/CHILD	B		ADMI NI STRATI VE & GENERAL	5.00		
33. 27	CARE E UNCLAIMED OTHER MONIES	В	204	ADMI NI STRATI VE & GENERAL	5.00	0	33. 27
JJ. 21	RECOVERED	в	- 300	ADMINI STRATI VE & GENERAL	5.00	0	33.27
	VENDING MACHINES	В		CAFETERI A	6. 01		
	CPR TRAIN OTH AHA COMMUNITY PHYSICIAN RECRUITMENT	B A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00		
	GAIN ON DISPOSAL	A		ADMINI STRATI VE & GENERAL	5.00		1
33. 33	TELEVISION AND RADIO SERVICE	А		OPERATION OF PLANT	7.00		
	TELEPHONE SERVICE	A		OPERATION OF PLANT	7.00		
	MI SC REV MI SC REV	B B		ADMI NI STRATI VE & GENERAL PHARMACY	5.00 15.00		
	ENTERTAI NMENT EXP	A		ADMI NI STRATI VE & GENERAL	5.00		
	EMPLOYEE USE OF AUTO	A		ADMI NI STRATI VE & GENERAL	5.00		
	DONATI ONS VHA OPPORTUNI TY	A A		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTME	5.00 NT 4.00		
	VHA OPPORTUNI TY	A		ADMI NI STRATI VE & GENERAL	5.00		
33.43	VHA OPPORTUNI TY	A	-89	OPERATION OF PLANT	7.00	0	33.43
		A		HOUSEKEEPI NG	9.00		
	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		DIETARY CENTRAL SERVICES & SUPPLY	10.00 14.00		
	VHA OPPORTUNI TY	A		PHARMACY	15.00		33.47
	VHA OPPORTUNI TY	А		ADULTS & PEDIATRICS	30.00		
	VHA OPPORTUNI TY VHA OPPORTUNI TY	A A		I NTENSI VE CARE UNI T SUBPROVI DER – I RF	31.00 41.00		
	VHA OPPORTUNI TY	A		OPERATING ROOM	50.00		
33. 52	VHA OPPORTUNI TY	A	-22, 091	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 52
	VHA OPPORTUNI TY	A		CARDIAC CATHETERIZATION	59.00		
აა. 54		A		LABORATORY ONCOLOGY	60.00 60.01		
	VHA OPPORTUNI TY VHA OPPORTUNI TY	А	- 2301	UNCOLOGI			
33.55	VHA OPPORTUNITY VHA OPPORTUNITY VHA OPPORTUNITY	A A		RESPIRATORY THERAPY	65.00	0	33.56
33. 55 33. 56 33. 57	VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY	A A	-2, 799 -38	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	33. 57
33. 55 33. 56 33. 57 33. 58	VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY	A A A	-2, 799 -38 -66	RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY	65.00 66.00 69.00	0 0	33. 57 33. 58
33. 55 33. 56 33. 57 33. 58 33. 59	VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY	A A	-2, 799 -38 -66 -7	RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY CARDI AC REHAB	65.00 66.00 69.00 69.01	0 0 0	33. 57 33. 58 33. 59
33. 55 33. 56 33. 57 33. 58 33. 59 33. 60 33. 61	VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY	A A A A	-2, 799 -38 -66 -7 -228 -643	RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY CARDI AC REHAB CLI NI C EMERGENCY	65.00 66.00 69.00 69.01 90.00 91.00	0 0 0 0	33. 57 33. 58 33. 59 33. 60 33. 61
33. 55 33. 56 33. 57 33. 58 33. 59 33. 60 33. 61 33. 62	VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY VHA OPPORTUNI TY	A A A A A	-2, 799 -38 -66 -7 -228 -643 -91	RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY CARDI AC REHAB CLI NI C	65.00 66.00 69.00 69.01 90.00		33. 57 33. 58 33. 59 33. 60 33. 61

33.65 ELIMINATING ENTRIES A -66, 33.65 ELIMINATING ENTRIES A -106, 33.66 ELIMINATING ENTRIES A -106, 33.67 ELIMINATING ENTRIES A -47, 33.68 ELIMINATING ENTRIES A -110, 33.71 ELIMINATING ENTRIES A -330, 33.72 ELIMINATING ENTRIES A -26, 33.73 ELIMINATING ENTRIES A -57, 33.74 ELIMINATING ENTRIES A -141, 33.75 ELIMINATING ENTRIES A -29, 33.76 ELIMINATING ENTRIES A -29, 33.76 ELIMINATING ENTRIES A -29, 33.77 ELIMINATING ENTRIES A -29, 33.77 ELIMINATING ENTRIES A -29, 33.78 ELIMINATING ENTRIES A -57, 33.78 ELIMINATING ENTRIES A -24,	F	to be Adjusted	Worksheet A-8 Date/Time Pre 11/26/2018 2:	pared:
1.00 2.00 33.64 FI NANCE DI SCOUNT PAYMENTS A 6, 33.65 ELI MI NATI NG ENTRI ES A -66, 33.66 ELI MI NATI NG ENTRI ES A -106, 33.67 ELI MI NATI NG ENTRI ES A -106, 33.71 ELI MI NATI NG ENTRI ES A -47, 33.71 ELI MI NATI NG ENTRI ES A -110, 33.72 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.74 ELI MI NATI NG ENTRI ES A -57, 33.74 ELI MI NATI NG ENTRI ES A -29, 33.75 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -65, 33.77 ELI MI NATI NG ENTRI ES A -57, 33.77 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -57,	To/From Which the Amount is Cost Center 3.00 646 ADMI NI STRATI VE & GENERAL	to be Adjusted		
1.00 2.00 33.64 FI NANCE DI SCOUNT PAYMENTS A 6, 33.65 ELI MI NATI NG ENTRI ES A -66, 33.66 ELI MI NATI NG ENTRI ES A -106, 33.67 ELI MI NATI NG ENTRI ES A -106, 33.71 ELI MI NATI NG ENTRI ES A -47, 33.71 ELI MI NATI NG ENTRI ES A -110, 33.72 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.74 ELI MI NATI NG ENTRI ES A -57, 33.74 ELI MI NATI NG ENTRI ES A -29, 33.75 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -65, 33.77 ELI MI NATI NG ENTRI ES A -57, 33.77 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -57,	To/From Which the Amount is Cost Center 3.00 646 ADMI NI STRATI VE & GENERAL	to be Adjusted	Wkst 17 Raf	
1.00 2.00 33.64 FI NANCE DI SCOUNT PAYMENTS A 6, 33.65 ELI MI NATI NG ENTRI ES A -66, 33.66 ELI MI NATI NG ENTRI ES A -106, 33.67 ELI MI NATI NG ENTRI ES A -106, 33.71 ELI MI NATI NG ENTRI ES A -47, 33.71 ELI MI NATI NG ENTRI ES A -110, 33.72 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.74 ELI MI NATI NG ENTRI ES A -57, 33.74 ELI MI NATI NG ENTRI ES A -29, 33.75 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -65, 33.77 ELI MI NATI NG ENTRI ES A -57, 33.77 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -57,	3.00 646 ADMI NI STRATI VE & GENERAL		Wkst A_7 Rof	
1.00 2.00 33.64 FI NANCE DI SCOUNT PAYMENTS A 6, 33.65 ELI MI NATI NG ENTRI ES A -66, 33.66 ELI MI NATI NG ENTRI ES A -106, 33.67 ELI MI NATI NG ENTRI ES A -106, 33.71 ELI MI NATI NG ENTRI ES A -47, 33.71 ELI MI NATI NG ENTRI ES A -110, 33.72 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.74 ELI MI NATI NG ENTRI ES A -57, 33.74 ELI MI NATI NG ENTRI ES A -29, 33.75 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -65, 33.77 ELI MI NATI NG ENTRI ES A -57, 33.77 ELI MI NATI NG ENTRI ES A -29, 33.76 ELI MI NATI NG ENTRI ES A -57,	3.00 646 ADMI NI STRATI VE & GENERAL		Wkst A-7 Rof	
1.00 2.00 33.64 FI NANCE DI SCOUNT PAYMENTS A 6, 33.65 ELI MI NATI NG ENTRI ES A -66, 33.66 ELI MI NATI NG ENTRI ES A -106, 33.67 ELI MI NATI NG ENTRI ES A -106, 33.71 ELI MI NATI NG ENTRI ES A -47, 33.71 ELI MI NATI NG ENTRI ES A -110, 33.72 ELI MI NATI NG ENTRI ES A -26, 33.73 ELI MI NATI NG ENTRI ES A -26, 33.74 ELI MI NATI NG ENTRI ES A -57, 33.75 ELI MI NATI NG ENTRI ES A -24, 33.77 ELI MI NATI NG ENTRI ES A -26, 33.77 ELI MI NATI NG ENTRI ES A -26, 33.75 ELI MI NATI NG ENTRI ES A -26, 33.77 ELI MI NATI NG ENTRI ES A -26, 33.77 ELI MI NATI NG ENTRI ES A -57, 33.77 ELI MI NATI NG ENTRI ES A -57,	3.00 646 ADMI NI STRATI VE & GENERAL		Wkst A_7 Rof	
33. 64 FI NANCE DI SCOUNT PAYMENTS A 6, 33. 65 ELI MI NATI NG ENTRI ES A -66, 33. 65 ELI MI NATI NG ENTRI ES A -106, 33. 66 ELI MI NATI NG ENTRI ES A -106, 33. 67 ELI MI NATI NG ENTRI ES A -47, 33. 68 ELI MI NATI NG ENTRI ES A -110, 33. 71 ELI MI NATI NG ENTRI ES A -330, 33. 72 ELI MI NATI NG ENTRI ES A -26, 33. 73 ELI MI NATI NG ENTRI ES A -57, 33. 74 ELI MI NATI NG ENTRI ES A -141, 33. 75 ELI MI NATI NG ENTRI ES A -26, 33. 74 ELI MI NATI NG ENTRI ES A -57, 33. 74 ELI MI NATI NG ENTRI ES A -29, 33. 75 ELI MI NATI NG ENTRI ES A -65, 33. 77 ELI MI NATI NG ENTRI ES A -57, 33. 78 ELI MI NATI NG ENTRI ES A -57, 33. 78	646 ADMI NI STRATI VE & GENERAL	4 00		
33. 65 ELI MI NATI NG ENTRI ES A -66, 33. 65 ELI MI NATI NG ENTRI ES A -106, 33. 66 ELI MI NATI NG ENTRI ES A -106, 33. 67 ELI MI NATI NG ENTRI ES A -47, 33. 68 ELI MI NATI NG ENTRI ES A -410, 33. 71 ELI MI NATI NG ENTRI ES A -330, 33. 72 ELI MI NATI NG ENTRI ES A -26, 33. 73 ELI MI NATI NG ENTRI ES A -57, 33. 74 ELI MI NATI NG ENTRI ES A -141, 33. 75 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -65, 33. 77 ELI MI NATI NG ENTRI ES A -57, 33. 78 ELI MI NATI NG ENTRI ES A -57, 33. 78 ELI MI NATI NG ENTRI ES A -24,			5.00	
33. 66 ELI MI NATI NG ENTRI ES A -106, 33. 67 ELI MI NATI NG ENTRI ES A -47, 33. 68 ELI MI NATI NG ENTRI ES A -410, 33. 71 ELI MI NATI NG ENTRI ES A -110, 33. 71 ELI MI NATI NG ENTRI ES A -330, 33. 72 ELI MI NATI NG ENTRI ES A -26, 33. 73 ELI MI NATI NG ENTRI ES A -57, 33. 74 ELI MI NATI NG ENTRI ES A -141, 33. 75 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -65, 33. 77 ELI MI NATI NG ENTRI ES A -57, 33. 78 ELI MI NATI NG ENTRI ES A -57, 33. 78 ELI MI NATI NG ENTRI ES A -24,	SAQIMCH DHVC DDACT MCMT	5.00		33.64
33. 67 ELI MI NATI NG ENTRI ES A -47, 33. 68 ELI MI NATI NG ENTRI ES A -110, 33. 71 ELI MI NATI NG ENTRI ES A -330, 33. 72 ELI MI NATI NG ENTRI ES A -26, 33. 73 ELI MI NATI NG ENTRI ES A -26, 33. 74 ELI MI NATI NG ENTRI ES A -57, 33. 74 ELI MI NATI NG ENTRI ES A -141, 33. 75 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -65, 33. 77 ELI MI NATI NG ENTRI ES A -65, 33. 77 ELI MI NATI NG ENTRI ES A -224,		192.14		33.65
33. 68 ELIMINATING ENTRIES A -110, 33. 71 ELIMINATING ENTRIES A -330, 33. 72 ELIMINATING ENTRIES A -26, 33. 73 ELIMINATING ENTRIES A -26, 33. 73 ELIMINATING ENTRIES A -57, 33. 74 ELIMINATING ENTRIES A -141, 33. 75 ELIMINATING ENTRIES A -29, 33. 76 ELIMINATING ENTRIES A -65, 33. 77 ELIMINATING ENTRIES A -57, 33. 78 ELIMINATING ENTRIES A -224,	598MGH WORK SOLUTIONS	194.04		33.66
33. 71 ELIMINATING ENTRIES A -330, 33. 72 ELIMINATING ENTRIES A -26, 33. 73 ELIMINATING ENTRIES A -26, 33. 73 ELIMINATING ENTRIES A -57, 33. 74 ELIMINATING ENTRIES A -141, 33. 75 ELIMINATING ENTRIES A -29, 33. 76 ELIMINATING ENTRIES A -65, 33. 77 ELIMINATING ENTRIES A -57, 33. 78 ELIMINATING ENTRIES A -224,	D41 LUNG CENTER	192.12		
33. 72 ELI MI NATI NG ENTRI ES A -26, 33. 73 ELI MI NATI NG ENTRI ES A -57, 33. 74 ELI MI NATI NG ENTRI ES A -141, 33. 75 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -29, 33. 76 ELI MI NATI NG ENTRI ES A -65, 33. 77 ELI MI NATI NG ENTRI ES A -57, 33. 77 ELI MI NATI NG ENTRI ES A -224, 33. 77 ELI MI NATI NG ENTRI ES A -224,	484 MGH MARION SURGEONS	192.15		00.00
33. 73 ELIMINATING ENTRIES A -57. 33. 74 ELIMINATING ENTRIES A -141, 33. 75 ELIMINATING ENTRIES A -141, 33. 75 ELIMINATING ENTRIES A -29, 33. 76 ELIMINATING ENTRIES A -65, 33. 77 ELIMINATING ENTRIES A -65, 33. 78 ELIMINATING ENTRIES A -57, 33. 78 ELIMINATING ENTRIES A -24,	963MGH FMC SOUTH	192.17		33.71
33. 74 ELIMINATING ENTRIES A -141, 33. 75 ELIMINATING ENTRIES A -29, 33. 76 ELIMINATING ENTRIES A -65, 33. 77 ELIMINATING ENTRIES A -65, 33. 78 ELIMINATING ENTRIES A -57, 33. 78 ELIMINATING ENTRIES A -24,	464 MGH FAIRM MED ASSOC	192.18		33. 72
33. 75 ELIMINATING ENTRIES A -29, 33. 76 ELIMINATING ENTRIES A -65, 33. 77 ELIMINATING ENTRIES A -57, 33. 78 ELIMINATING ENTRIES A -52,	508MGH FMC MARION	192.19		33.73
33. 76 ELIMINATING ENTRIES A -65, 33. 77 ELIMINATING ENTRIES A -57, 33. 78 ELIMINATING ENTRIES A -24,	337MGH FMC GAS CITY	193.02	0	33.74
33. 77ELIMINATING ENTRIESA-57,33. 78ELIMINATING ENTRIESA-24,	547MGH FMC SWAYZEE	193.05		
33.78 ELIMINATING ENTRIES A -24,	154 MGH PEDIATRIC CTR	193.06	0	33.76
	558UROLOGY	192.06	0	33.77
	230MGH SPECIALTY PHYS	193.07	0	33.78
33. 79 LOBBYING COSTS A -18,	889 ADMI NI STRATI VE & GENERAL	5.00	0	33.79
33. 80 LOBBYING COSTS A	-51 PHARMACY	15.00	0	33.80
33. 81 LOBBYING COSTS A -	728ONCOLOGY	60.01	0	33.81
33. 82 LOBBYING COSTS A	-18 RESPI RATORY THERAPY	65.00	0	33.82
33. 83 LOBBYING COSTS A	-54 PHYSI CAL THERAPY	66.00	0	33.83
33. 84 OPERATING INTEREST INCOME B -35,	971 NEW CAP REL COSTS-BLDG & FLXT	1.00	11	33.84
33. 85 ED ON CALL SVC A/C 7000. 2512 A -2, 538,	823 ADMI NI STRATI VE & GENERAL	5.00	0	33.85
33. 86 XI X ASSESSMENT FEE A/C A -8, 332, 7200. 7892	197 ADMI NI STRATI VE & GENERAL	5.00	0	33.86
33.87 SELF INSURANCE EXPENSE A -2,945,	036 EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.87
	130 LABORATORY	60.00	o	33.88
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)				50.00

(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.

	Financial Syste		MARION GENER				eu of Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C	CCN: 15-0011	Peri od:	Worksheet A-8	3-2
						From 07/01/2017 To 06/30/2018		epared: 38 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	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	11, 215	11, 215		0 0	0	1.00
2.00	69.00	ELECTROCARDI OLOGY	53, 655	53, 655		o l	0	2.00
3.00	50.00	OPERATING ROOM	1, 132, 997	1, 132, 997		o l	0	3.00
4.00		CLINIC	10, 571	10, 571			0	4.00
5.00		EMERGENCY	165,000				0	5.00
6.00		LABORATORY	12,600				0	6.00
7.00		RADI OLOGY-DI AGNOSTI C	150,000				0	
8.00	0.00		130,000	130,000			0	8.00
9.00	0.00		0	-			0	9,00
			0	0			0	
10.00	0.00		1 50(000	0			0	10.00
200.00			1, 536, 038				0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
-					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		SUBPROVIDER - IRF	0			0 0		
2.00		ELECTROCARDI OLOGY	0			0 0	-	
3.00		OPERATING ROOM	0			0 0	-	
4.00		CLINIC	0	0		0 0	0	4.00
5.00	91.00	EMERGENCY	0	0		0 0	0	5.00
6.00	60.00	LABORATORY	0	0		0 0	0	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	7.00
8.00	0.00		0	0		0 0	0	8.00
9.00	0.00		0	0		o l	0	9.00
10.00	0.00		0	0		o l	0	10.00
200.00			0	0		o l	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	1
1.00	41.00	SUBPROVIDER - IRF	0	0		0 11, 215		1.00
2.00		ELECTROCARDI OLOGY	0			53, 655		2.00
3.00		OPERATING ROOM	0			1, 132, 997		3.00
4.00		CLINIC	0	0		10, 571		4,00
4.00 5.00		EMERGENCY	0	0		165,000	1	5.00
6.00		LABORATORY	0	0		12,600		6.00
7.00		RADI OLOGY-DI AGNOSTI C	0			150,000	•	7.00
	0.00		0			ol 150,000	1	1
8.00			-			-	-	8.00
9.00	0.00		0	-				9.00
10.00	0.00		0					10.00
200.00	1		0	0		0 1, 536, 038	1	200.00

	Financial Systems	MARION GENER				u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2017	Worksheet B Part I	
					06/30/2018		
			CAPITAL			11/26/2018 2:	38 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FIXT	BENEFITS		& GENERAL	
		Allocation (from Wkst A		DEPARTMENT			
		col. 7)					
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS		- 		1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	12, 552, 381					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	15, 482, 086		15, 956, 435			4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	19, 500, 608		2, 932, 608	3 24, 489, 092	24, 489, 092	5.00
6.00 6.01	00601 CAFETERIA	1, 274, 340	0 165, 321		1, 439, 661	0 272, 868	
6.02	00602 CAFETERIA	1, 274, 340	005, 521		0 1, 437, 001	0	6. 02
7.00	00700 OPERATION OF PLANT	5, 224, 185	3, 336, 917	207, 064	8, 768, 166	1, 661, 883	
8.00	00800 LAUNDRY & LINEN SERVICE	424, 894			496, 816	94, 165	8.00
9.00	00900 HOUSEKEEPI NG	2, 602, 772	110, 963	(2, 713, 735	514, 350	9.00
10.00	01000 DI ETARY	515, 607		(743, 387	140, 899	•
13.00	01300 NURSI NG ADMI NI STRATI ON	961, 895		314, 999		246, 507	•
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	378, 847 3, 273, 575		39, 263 917, 893		94, 621 814, 240	
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	3, 213, 375	104, 490	717, 093	4,270,904	014,240	15.00
30.00	03000 ADULTS & PEDIATRICS	7, 577, 720	1, 470, 360	2, 281, 776	5 11, 329, 856	2, 147, 416	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 615, 327	341, 058	682, 387	3, 638, 772	689, 678	31.00
40.00	04000 SUBPROVI DER – I PF	0	0 0	(0 0	0	40.00
41.00	04100 SUBPROVIDER - IRF	1, 598, 798		338, 323	2, 263, 372	428, 990	•
42.00	04200 SUBPROVI DER	1 00/ 052	0))))			
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1,006,852	2 0	317, 206	1, 324, 058	250, 957	43.00
50.00	05000 OPERATI NG ROOM	12, 258, 047	1, 172, 700	(13, 430, 747	2, 545, 605	50.00
51.00	05100 RECOVERY ROOM	0	0	(0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 576, 814	704, 103	813, 645	6, 094, 562	1, 155, 139	54.00
57.00	05700 CT SCAN	1, 011, 419		179, 207		235, 376	•
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	505, 750		86, 983		123, 853	•
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 908, 154		221, 860		436, 229	1
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY	7,967,179		775, 367 339, 474		1, 741, 514	60.00 60.01
60.01	06002 RADIATION ONCOLOGY	1, 546, 588		339,472	1, 886, 062	357, 477	1
65.00	06500 RESPI RATORY THERAPY	2,007,573	, U	457, 767	2, 616, 978	496, 012	65.00
66.00	06600 PHYSI CAL THERAPY	1, 845, 302		548, 868		459, 465	66.00
69.00	06900 ELECTROCARDI OLOGY	931, 038		281, 386		281, 112	
69.01	06901 CARDI AC REHAB	184, 681		53, 347		53, 482	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	, v	(-	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	8, 425, 650			-	0 1, 596, 964	72.00
75.00	OUTPATIENT SERVICE COST CENTERS	0,423,030	и <u>ч</u>		0, 423, 030	1, 370, 704	/ 3.00
90.00	09000 CLINIC	545, 277	96, 395	100, 812	2 742, 484	140, 727	90.00
91.00	09100 EMERGENCY	4, 876, 559	376, 831	1, 346, 513		1, 250, 919	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0 0	(0 0	0	92.01
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1, 186, 687	141, 256	385, 464	1, 713, 407	324, 752	95.00
95.00	SPECIAL PURPOSE COST CENTERS	1, 100, 007	141, 250	305, 404	1, 713, 407	524,752	95.00
113.00	11300 I NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	124, 766, 605	12, 507, 145	13, 622, 212	2 122, 387, 146	18, 555, 200	•
	NONREIMBURSABLE COST CENTERS	1			1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	51, 235		11, 405	5 107, 876		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0		192.00
	19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL	111 244		24.240	U 145 422		192.02 192.03
	19204 LIFELINE	111, 364		34, 269	9 145, 633		192.03
	19205 OWNED PROPERTIES	83, 802	0	(83, 802		192.05
	19206 UROLOGY	1, 437, 492		116, 081		294, 458	
	19211 PARI SH NURSI NG	52, 324		11, 977			192.08
192.08	19212 BI OTERRORI SM GRANT	37, 153	0	10, 121	47, 274	8, 960	192.09
192.09		0	0	(0		192.10
192. 09 192. 10	19214 BREAST PUMPS		0	39, 493		131, 498	•
192. 09 192. 10 192. 12	19209 LUNG CENTER	654, 294				342,622	192.14
192.09 192.10 192.12 192.14	19209 LUNG CENTER 19210 MGH PHYS PRACT MGMT	1, 467, 615		340, 071			102 15
192.09 192.10 192.12 192.14 192.15	19209 LUNG CENTER 19210 MGH PHYS PRACT MGMT 19215 MGH MARI ON SURGEONS	1, 467, 615 2, 367, 213	0	176, 683	3 2, 543, 896	482, 160	
192. 09 192. 10 192. 12 192. 14 192. 15 192. 16	19209 LUNG CENTER 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	1, 467, 615 2, 367, 213 1, 428, 834	0 0	176, 683 (2, 543, 896 1, 428, 834	482, 160 270, 815	192.16
192.09 192.10 192.12 192.14 192.15 192.16 192.17	19209 LUNG CENTER 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	1, 467, 615 2, 367, 213	6 O 6 O	176, 683	2, 543, 896 1, 428, 834 3, 385, 971	482, 160 270, 815 641, 763	192.16
192. 09 192. 10 192. 12 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19	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	1, 467, 615 2, 367, 213 1, 428, 834 3, 130, 246	3 0 0 2 0	176, 683 (255, 725	3 2, 543, 896 0 1, 428, 834 5 3, 385, 971 2 367, 664	482, 160 270, 815 641, 763 69, 686 156, 626	192. 16 192. 17 192. 18 192. 19
192.09 192.10 192.12 192.14 192.15 192.16 192.17 192.18 192.19 193.00	19209 LUNG CENTER 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAI RM MED ASSOC 19219 MGH FAI RM MED ASSOC 19200 NONPAI D WORKERS	1, 467, 615 2, 367, 213 1, 428, 834 3, 130, 246 333, 582 734, 586 0		176, 683 (255, 725 34, 082 91, 779 (2, 543, 896 1, 428, 834 3, 385, 971 367, 664 826, 365 0	482, 160 270, 815 641, 763 69, 686 156, 626 0	192. 16 192. 17 192. 18 192. 19 193. 00
192.09 192.10 192.12 192.14 192.15 192.16 192.17 192.18 192.19 193.00 193.01	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	1, 467, 615 2, 367, 213 1, 428, 834 3, 130, 246 333, 582		176, 683 (255, 725 34, 082 91, 779	2, 543, 896 1, 428, 834 3, 385, 971 367, 664 826, 365 0 1, 424, 491	482, 160 270, 815 641, 763 69, 686 156, 626	192. 16 192. 17 192. 18 192. 19 193. 00 193. 01

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/26/2018 2:38 pm
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT		ADMI NI STRATI VE & GENERAL
	0	1.00	4.00	4A	5.00
193. 03 19303 MGH HOSPI TALI STS	4, 015, 284	0	12, 63	7 4, 027, 921	763, 436 193. 03
193.04 19304 MGH MAR FAM PRACT	2, 962, 128	0	324, 23	9 3, 286, 367	622, 885 193. 04
193.05 19305 MGH FMC SWAYZEE	256, 686	0	26, 34	6 283, 032	53, 645 193. 05
193.06 19306 MGH PEDIATRIC CTR	1, 149, 328	0	83, 18	4 1, 232, 512	233, 605 193. 06
193.07 19307 MGH SPECIALTY PHYS	318, 513	0	27, 77	7 346, 290	65, 634 193. 07
193.08 19308 MGH FMC CONVERSE	343, 422	0	36, 51	0 379, 932	72, 011 193. 08
193.09 19309 MGH UPLAND HEALTH	1, 693, 680	0	146, 77	6 1, 840, 456	348, 833 193. 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	2, 690, 079	0	181, 22	1 2, 871, 300	544, 215 193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0 193. 15
194.0007963 HEART FAILURE CLINIC	27,069	0		0 27, 069	5, 131 194.00
194. 01 07950 MOW	0	0		0 0	0 194. 01
194.0207951 MENTAL HEALTH	0	0		0 0	0 194. 02
194. 03 07952 ADVERTI SI NG	259, 241	0	60, 87	7 320, 118	60, 674 194. 03
194.0407953 MGH WORK SOLUTIONS	737, 694	0	103, 58	2 841, 276	159, 452 194. 04
194. 05 07954 MGH TAYLOR UNI VERSI TY	136,030		10, 37		27, 748 194. 05
194.0807957 MGH SMMP BLDG	245, 930	0		0 245, 930	46, 613 194. 08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0	0 194.09
194.10 07959 MGH 106 LYONS BLDG	6,069	0		6,069	
194. 11 07960 FAI RMOUNT	24, 470			0 24, 470	
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	1,650	0		0 1,650	
194. 15 07965 TOBACCO GRANT	38, 371		7,66		
200.00 Cross Foot Adjustments		Ĭ	.,	0	200.00
201.00 Negative Cost Centers		0		0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	153, 694, 610	12, 552, 381	15, 956, 43	5 153, 694, 610	

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 07/01/2017	Worksheet B Part I	
			То		Date/Time Pre 11/26/2018 2:	pared: 38 pm
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS 6.00	6.01	6. 02	PLANT 7.00	LINEN SERVICE 8.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
6.00 00600 MAI NTENANCE & REPAI RS	0	4 740 500				6.00
6. 01 00601 CAFETERIA 6. 02 00602 CAFETERIA	0	1, 712, 529 1, 637, 128	1, 637, 128			6. 01 6. 02
7. 00 00700 OPERATION OF PLANT	0	0	39, 964	10, 470, 013		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	115, 495	706, 476	1
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	0	0	0	178, 190 365, 781	0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	24, 588	38, 043	0	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	8, 172	130, 253	7, 619	1
15. 00 01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	83, 038	167, 804	0	15.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	278, 990	2, 361, 179	172, 804	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	76, 402	547, 687	37, 251	1
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	0	0 39, 767	0 523, 911	0 19, 646	
42. 00 04200 SUBPROVI DER	0	0	0	0	0,040	
43. 00 04300 NURSERY	0	0	35, 258	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0	222, 711	1, 883, 181	125, 125	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	1, 003, 101	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	113, 432	1, 130, 685	51, 724	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	24, 431 5, 929	82, 262 97, 512	20, 267 0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	27, 587	275, 484	8, 344	1
60. 00 06000 LABORATORY	0	0	106, 347	715, 820	8	60.00
60. 01 06001 0NC0L0GY 60. 02 06002 RADI ATI 0N 0NC0L0GY	0	0	0	0	4, 239 0	60. 01 60. 02
65. 00 06500 RESPIRATORY THERAPY	0	0	50, 462	243, 508	4, 257	
66. 00 06600 PHYSI CAL THERAPY	0	0	24, 592	48, 155	14, 180	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0	40, 700 6, 941	434, 761 70, 893	5, 182 0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0, 941	70, 893	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
90. 00 09000 CLINIC	0	0	11, 488	154, 795	3, 203	90.00
91. 00 09100 EMERGENCY	0	0	169, 777	605, 135	204, 538	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.00 92.01
OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92.01
95. 00 09500 AMBULANCE SERVICES	0	0	62, 457	226, 837	25, 456	95.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 637, 128	1, 453, 033	10, 397, 371	703, 843	
NONREI MBURSABLE COST CENTERS			4.07(70 (40	0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	1, 276 0	72, 642 0		190. 00 192. 00
192.02 19202 VI SI TOR MEALS	0	75, 401	0	0	0	192. 02
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	0	0	0	0		192. 03 192. 04
192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES	0	0	0	0		192.04 192.05
192. 06 19206 UROLOGY	0	0	23, 219	0	0	192.06
192. 08 19211 PARI SH NURSI NG	0	0	1, 966	0		192.08
192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS	0	0	1, 188 0	0		192. 09 192. 10
192.12 19209 LUNG CENTER	0	0	9, 840	0	0	192. 12
192. 14 19210 MGH PHYS PRACT MGMT	0	0	59, 885	0		192.14
192.15 19215 MGH MARION SURGEONS 192.16 19216 MGH MGH MED ONC	0	0	34, 339	0		192. 15 192. 16
192. 17 19217 MGH FMC SOUTH	0	0	0	0		192.10
192. 18 19218 MGH FAI RM MED ASSOC	0	0	0	0		192.18
192. 19 19219 MGH FMC MARI ON 193. 00 19300 NONPAI D WORKERS		0	20, 640 0	0		192. 19 193. 00
193. 01 19301 MGH FMC NORTHWOOD	0	0	0	0		193.00
193.02 19302 MGH FMC GAS CITY	0	0	0	0		193.02
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT		0	0	0		193. 03 193. 04
193.05 19305 MGH FMC SWAYZEE	0	0	0	0	0	193. 05
193. 06 19306 MGH PEDIATRIC CTR	0	0	18, 544	0		193.06
193. 07 19307 MGH SPECIALTY PHYS	0	O	5, 286	0	85	193. 07

Health Financial Systems	MARION GENERA	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0011	Peri od:	Worksheet B	
				From 07/01/2017 To 06/30/2018		narod
				10 00/30/2018	11/26/2018 2:	38 pm
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6. 01	6.02	7.00	8.00	
193.08 19308 MGH FMC CONVERSE	0	0		0 0	-	193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 0		193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0	-	193. 10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0 0		193. 11
193. 12 19312 0B/GYN	0	0		0 0		193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0		193. 15
194.0007963 HEART FAILURE CLINIC	0	0		0 0		194.00
194. 01 07950 MOW	0	0		0 0		194.01
194.0207951MENTAL HEALTH	0	0		0 0		194. 02
194. 03 07952 ADVERTI SI NG	0	0	7, 0	73 0		194.03
194.0407953 MGH WORK SOLUTIONS	0	0		0 0	-	194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0		194.05
194.08 07957 MGH_SMMPBLDG	0	0		0 0		194.08
194.0907958MGH AMBUCARE BLDG	0	0		0 0		194.09
194.1007959MGH 106 LYONS BLDG	0	0		0 0		194. 10
194. 11 07960 FAI RMOUNT	0	0		0 0		194. 11
194. 12 07961 GAS_CLTY	0	0		0 0		194. 12
194. 13 07962 LYONS	0	0		0 0		194. 13
194. 14 07964 WABASH	0	0		0 0		194. 14
194.1507965TOBACCO GRANT	0	0	8	39 0	0	194. 15
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	1, 712, 529	1, 637, 1	10, 470, 013	706, 476	202.00

COST ALLOCATION - GRIEDAL SERVICE COSTS Provider CX: IS-OIL Part ad Important CX Part ad Importad CX Part ad Important CX	Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lieu	ı of Form CMS-:	2552-10
Cont Cont <th< td=""><td>COST ALLOCATION - GENERAL SERVICE COSTS</td><td></td><td>Provider CC</td><td>Fr</td><td>om 07/01/2017</td><td>Part I</td><td></td></th<>	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	Fr	om 07/01/2017	Part I	
Upsit Lenter Description MUSSING Part of the Service Part of the S				То	06/30/2018		
Product Summary Summary Summary Summary Summary 100 00000 Mex CAP RELIGN 53-BLO & FLAT 0.00 10.00	Cost Center Description	HOUSEKEEPING					
Deleval Skin to Cost Cost Cost <				ADMINI STRATI ON			
1.00 00000 [KR CAP ILEL COSTS=BLIC & FLAX 4.00 0.00 00000 [CAP IVE ENDERT FOR CATERING 4.00 0.00 00000 [CAP ILES AN 6.00 0.00 00000 [CAP ILES AN 7.00 0.00 00000 [CAP ILES AN 7.00 0.00 00000 [CAP ILES AN 6.00 0.00 00000 [CAP ILES AN 6.00 0.00 00000 [CAP ILES AN 7.00 0.00 00000 [CAP ILES AN 5.404,011 0.00 00000 [CAP ILES AN 7.00 0.00	CENEDAL SEDVICE COST CENTEDS	9.00	10.00	13.00	14.00	15.00	
5.00 DOBOD ANNUESTERATUPE & GENERAL 5.00 DOBOD ANNUESTERATUPE & GENERAL 5.00 6.00 6.00 DOBOD (CAFETERA A 6.00 7.00 7.0							1.00
6.00 BUSCOL WIN HILLMARGE & HEAVAI HIS 6.00							
6.02 00000 CAPETERIA 6.02 8.00 00000 LANGERT AL LINEN SERVICE 3.005.275 8.01 00000 LANGERT AL LINEN SERVICE 3.005.275 9.01 00000 LANGERT AL LINEN SERVICE 3.002.205 9.01 00000 LANGERT AL LINEN SERVICE 3.002.205 9.01 13.00 00000 LANGERT AL LINEN SERVICE 3.001 9.00 13.00 00000 LANGERT AL LINEN SERVICE 3.001 9.00 13.00 00000 LANGERT AL LINEN SERVICE 3.001 9.00 13.00 00000 14.005 14.000 9.00 00100 HTMAN SERVICE 175.006 79.900 114.9551 9.00 01100 HTMAN SERVICE 110.000 0 4.000 9.00 01100 HTMAN SERVICE 110.000 0 4.000 9.00 014.0000 0.000 0 0 4.000 0 0 0 0 0 0 0 0 0							
7.00 00700 DEENT IN OF PLANT 7.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>							1
9. 00 00000 0005H ETAY 3. 406, 273 9. 00 13. 00 01300 AURES NE, AURIN ASTRATION 15, 668 1, 300, 025 16, 625, 390 810, 220 10. 00 13. 00 01300 AURES NE, AURIN ASTRATION 15, 668 1, 300, 025 810, 220 13. 00 15. 00 01500 AURES NE, AURIN ASTRATION 15, 658 134, 00, 02 16, 625, 390 110, 020 5, 404, 917 15. 00 01000 AURES NE, AURIN ASTRATION 277, 000 779, 714 431, 581 10, 00 0 0, 00 0 64, 00 11, 00 10, 00							
10.00 01000 DIETARY 50.018 1.300, 01300 1.625, 370 10.00 14.00 01400 CENTRAL SERVICES & SUPPLY 78, 341 0 0, 0 0 0 0 0 10.00 14.00 01400 CENTRAL SERVICES & SUPPLY 78, 341 0 <t< td=""><td>8.00 00800 LAUNDRY & LINEN SERVICE</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	8.00 00800 LAUNDRY & LINEN SERVICE						
13.00 01300 HURSING ADM INISTRATION 15, 668 0 1, 625, 390 11, 600 14.00 01600 FRAMLEXEV 43, 671 0 0 0 12, 00 15.00 DISOD FRAMLEXEV 5, 00, 01600 FRAMLEXEV 43, 671 0<			1, 300, 205				
15. 00 01500 PHARMACY 43, 371 0 0 5, 404, 977 15. 00 01 0000 ADULT 5A PEDIATRICS 727, 006 779, 204 431, 658 231, 008 30, 00 01 0000 SUBPROVID FR 114, 551 0 30, 00 114, 551 0 30, 00 01 000 SUBPROVID FR 1175, 444 110, 400 61, 443 68, 80 0 41, 00 01 000 SUBPROVID FR 1175, 444 110, 400 61, 443 68, 80 0 41, 00 0 0 0 42, 00 01 000 SUBPROVID FR 116, 700 0 0 54, 477 0 0 42, 00 42, 00 43, 00 0 44, 00 50, 00 <t< td=""><td>13.00 01300 NURSING ADMINISTRATION</td><td>15, 668</td><td>0</td><td></td><td></td><td></td><td>13.00</td></t<>	13.00 01300 NURSING ADMINISTRATION	15, 668	0				13.00
ImpArt Funt Description Description Description 00 03000 UNTERS FUNCT COST CENTERS 227,006 118,048 28,638 91,00 01 00 03100 UNTERS FUNCT COST CENTERS 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>5 101 917</td><td></td></td<>						5 101 917	
11.00 03100 INTLENSIVE CARE UNIT 200.553 134.038 118.048 28.638 0 <		43,071	0			3, 404, 717	13.00
40. 00 04000 SUBPROV DER IPF 0							
142 00 04200 SUBFROND EER 0 0 0 12 0 0 0 12 0 </td <td></td> <td>200, 355</td> <td>134, 030</td> <td>048</td> <td></td> <td></td> <td></td>		200, 355	134, 030	048			
43. 00 0 0 0 54.477 0 0 43. 00 ANCLLARY SERVIC COST CENTERS 40.00 0 344.106 49.094 0 0 0 50.00 05000 DFECNTING ROOM 0 <td></td> <td></td> <td></td> <td>61, 443</td> <td></td> <td></td> <td></td>				61, 443			
MCULLARY SERVICE COST CENTRES Non-transmission 0.00 00000FERATIN. ROW 0 0 344, 106 49, 074 0 55.00 51.00 05100 PERATIN. ROW 0 0 0 0 0 0 51.00 65.00 05000 MARDIT. C. RESOWACE IMAGING (URI) 0 0 0 24, 547 0 56.00 05.00 05000 CARBIA C. CATHERENDANCE IMAGING (URI) 0 <		-	-	0 54, 477	-		
11.00 05100 RECOVERY ROOM 0			-				
54.00 05400 RADIOLOSY-DLAGNOST LC 206, B21 0 0 24, 547 0 55.00 57.00 05500 MAGNETIC RESONANCE INAGENG (MRI) 0 0 0 0 0 0 0 57.00 57.00 58.00 05800 MAGNETIC RESONANCE INAGENG (MRI) 0			-		49, 094 0		
B8 00 S5800 MARETIC RESONANCE IMAGING (MRI) 0	54.00 05400 RADI OLOGY-DI AGNOSTI C		0	0	24, 547	0	54.00
99 00 05500 CARDIA C, CATHETERI ZATI ON 62, 673 0 42, 623 32, 729 0 99 00 60.00 GEOCU LABORATORY 175, 484 0 0 44, 091 60.01 60.01 GEOCU LABORATORY 131, 613 0 77, 967 45, 003 65.00 66.00 GEOCU PHYSI CAL THERAPY 131, 613 0 77, 967 45, 003 65.00 69.00 06500 C LECTROCARDI 0LOGY 84, 608 0 62, 884 20, 456 69.00 69.01 06900 C LECTROCARDI 0LOGY 84, 608 0 62, 884 20, 456 69.00 71.00 72.00 0 0 0 0 72.00 73.00 0173.00 DIVEL DEV CHARGED TO PATI ENTS 0<		9, 401	0	0	0	-	
60.01 06001 06001 06001 06001 0		62, 673	0	42, 623	32, 729		
60.02 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>			0	0			
66.00 06600 PHYSICAL THERAPY 0 0 37,977 0 0 66,00 06.00 06900 LECTEXCANDIOLOCY 84,608 062,884 20,456 0 69,00 07.00 OPTO MEDICA. ENARCED TO PATIENTS 0		0	0	0	4, 091		1
69:00 06900 ELECTROCARD OLOGY 84.008 0 62.884 20.456 0 69:00 71:00 OTION MEDI CARL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71:00 72:00 OZOOD IMPL GEV CHARGED TO PATIENTS 0 0 0 0 72:00 73:00 0 0 0 0 73:00 73:00 0 0 0 0 73:00 0 0 0 0 0 0 73:00 0			0		45, 003		
69.01 06901 CARDIA C REHAB 94,009 0 10,725 0 0 69.01 71.00 07000 KEDI C4. SUPPLIES C CHARGED TO PATIENTS 0 0 0 0 72.00 72.00 0		Ŭ	0		0 20 456	-	
12:00 00 0 <td>69. 01 06901 CARDI AC REHAB</td> <td></td> <td>Ö</td> <td></td> <td>0</td> <td>0</td> <td>69. 01</td>	69. 01 06901 CARDI AC REHAB		Ö		0	0	69. 01
73.00 OR300 DRUGS CHARGED TO PATIENTS O O S, 404, 917 73.00 OUTPATIENT SERVICE COST CENTERS		Ŭ	0	Ű	0		
90. 00 00 09000 (CLI NI C 62, 673 0 17, 751 0 0 90. 00 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 752, 078 16, 281 226, 318 28, 638 0 91. 00 92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 92. 01 95. 00 09500 AMBULANCE SERVI CES 21, 936 0 96, 501 8, 182 0 95. 00 9500 MBULANCE SERVI CES 21, 936 0 96, 501 8, 182 0 95. 00 113.00 11300 ITERRE REIMBURSOBE COST CENTERS 113. 00 1300 1, 617, 898 413, 205 5, 404, 917 118. 00 100.00 190000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6, 267 0 0 0 192. 00 192. 00 120. 01 92002 1751 ST TE OFFEE SHOP & CANTEEN 6, 267 0 0 0 192. 02 192. 02 192. 02 192. 02 192. 02 192. 02	73.00 07300 DRUGS CHARGED TO PATIENTS	-	0	-	0	-	
91 00 00 00 00 <		62 673	0	17 751	0	0	90.00
92.01 09201 09507 00 0			-		-		
OTHER REI MBURSABLE COST CENTERS 95.00 OPECIAL PURPOSE COST CENTERS 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 11300 11300 11300 11300 11300 11300 11300 11300 11300 11300 11300 11300 11300 11300 113.00 1300 1 13.00 19.00 19.00 19.00 19.00							

Health Financial Systems	MARION GENERAL	- HOSPI TAL		In Lie	u of Form CMS-2552-	.10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2017 To 06/30/2018		
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI (
	9.00	10.00	13.00	SUPPLY 14.00	15.00	_
193.07 19307 MGH SPECIALTY PHYS	9.00	10.00	13.00	0 0	0 193. (07
193. 07 19307 MGH SPECIALTY PHYS 193. 08 19308 MGH FMC CONVERSE	0	0		0 8, 182		
193. 09 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH	0	0		0 8, 182	0 193. (
193. 10 19310 MGH MGH WOMENS CTR	0	0		49,094	0 193. 0	
193. 11 19311 MGH MGH PSYCHLATRY	0	0		0 0	0193.	
193. 12 19312 OB/GYN	0	0		0 90,005	0 193.	
193. 15 19315 MGH RIVER VIEW BLDG	0	0		90,003	0 193.	
194. 00 07963 HEART FAILURE CLINIC	0	0		0 0	0 193.	
194. 01 07950 MOW	0	125, 434	·		0 194.0	
194. 02 07951 MENTAL HEALTH	0	134, 641			0 194.0	
194. 03 07952 ADVERTI SI NG	0	134, 041			0 194.0	
194. 04 07953 MGH WORK SOLUTI ONS	0	0		0 32,729	0 194.0	
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0		0 02, 727	0 194. 0	
194. 08 07957 MGH_SMMPBLDG	0	0		0 0	0 194. 0	
194. 09 07958 MGH AMBUCARE BLDG	0	0		0 0	0 194. 0	
194. 10 07959 MGH 106 LYONS BLDG	0	0		0 0	0 194.	
194. 11 07960 FAI RMOUNT	0	0		0 0	0 194.	
194. 12 07961 GAS CI TY	0	0)	0 0	0 194.	12
194. 13 07962 LYONS	0	0		0 0	0 194.	13
194.1407964 WABASH	0	0		0 0	0 194.	14
194. 15 07965 TOBACCO GRANT	0	0)	0 0	0 194. 1	15
200.00 Cross Foot Adjustments					200. (00
201.00 Negative Cost Centers	0	0)	0 0	0 201.0	00
202.00 TOTAL (sum lines 118 through 201)	3, 406, 275	1, 300, 205	1, 625, 39	818, 228	5, 404, 917 202. (00

alth Financial Systems ST ALLOCATION - GENERAL SERVICE		NERAL HOSPITAL Provider	CCN: 15-0011	In Lieu of Form Period: Workshee	
				From 07/01/2017 Part I To 06/30/2018 Date/Tir	me Prepare 018 2:38 p
Cost Center Descripti	on Subtotal	Intern & Residents Cos & Post Stepdown	Total t	11/20/20	<u>Jio 2.30 p</u>
		Adjustments			
GENERAL SERVICE COST CENTER	24.00	25.00	26.00		
00 00100 NEW CAP REL COSTS-BLD					1.
00 00400 EMPLOYEE BENEFITS DEP					4.
00 00500 ADMI NI STRATI VE & GENE	RAL				5.
00 00600 MAI NTENANCE & REPAI RS					6.
01 00601 CAFETERI A 02 00602 CAFETERI A					6. 6.
00 00700 OPERATION OF PLANT					7.
00 00800 LAUNDRY & LINEN SERVI	CE				8.
00 00900 HOUSEKEEPI NG					9.
. 00 01000 DI ETARY					10.
. 00 01300 NURSI NG ADMI NI STRATI O					13.
. 00 01400 CENTRAL SERVICES & SU	PPLY				14.
. 00 01500 PHARMACY					15.
I NPATI ENT ROUTI NE SERVI CE C 0.00 03000 ADULTS & PEDI ATRI CS		064	0 18, 342, 0	61	30.
. 00 03000 ADULTS & PEDIATRICS . 00 03100 INTENSIVE CARE UNIT	18, 342, 5, 471,		0 18, 342, 0 0 5, 471, 0		30.
. 00 04000 SUBPROVIDER - IPF	5,471,		0 5,471,0	Ő	40.
. 00 04100 SUBPROVIDER - IRF	3, 631,	404	0 3, 631, 4	04	41.
. 00 04200 SUBPROVI DER			0	0	42.
. 00 04300 NURSERY	1, 664,	750	0 1, 664, 7	50	43.
ANCILLARY SERVICE COST CENT					
00 05000 OPERATING ROOM	19, 064,		0 19,064,3		50.
. 00 05100 RECOVERY ROOM	0.77/	-	0	0	51.
. 00 05400 RADI OLOGY-DI AGNOSTI C . 00 05700 CT SCAN	8, 776,		0 8,776,9		54.
.00 05700 CT SCAN .00 05800 MAGNETIC RESONANCE IM	AGING (MRI) 1,613, 880,		0 1, 613, 5 0 880, 7		57. 58.
00 05900 CARDI AC CATHETERI ZATI			0 3, 187, 2		59.
. 00 06000 LABORATORY	11, 976,		0 11, 976, 5		60.
. 01 06001 ONCOLOGY	2, 251,		0 2, 251, 8		60.
. 02 06002 RADIATION ONCOLOGY		0	0	0	60.
. 00 06500 RESPI RATORY THERAPY	3, 665,		0 3, 665, 8		65.
. 00 06600 PHYSI CAL THERAPY	3, 008,		0 3, 008, 5		66.
. 00 06900 ELECTROCARDI OLOGY	2, 412,		0 2, 412, 8		69.
. 01 06901 CARDIAC REHAB . 00 07100 MEDICAL SUPPLIES CHAR	CED TO DATIENTS		0 518, 2 0	25	69. 71.
. 00 07200 IMPL. DEV. CHARGED TO		-	0	0	72.
. 00 07300 DRUGS CHARGED TO PATI			0 15, 427, 5	31	73.
OUTPATIENT SERVICE COST CEN					
. 00 09000 CLI NI C	1, 133,	121	0 1, 133, 1	21	90.
. 00 09100 EMERGENCY	9, 889,	587	0 9, 889, 5	87	91.
. 00 09200 OBSERVATION BEDS (NON			0	-	92.
. 01 09201 OBSERVATI ON BEDS (DI S		0	0	0	92.
OTHER REIMBURSABLE COST CEN . 00 09500 AMBULANCE SERVICES	2, 479,	520	0 2, 479, 5	28	95.
SPECIAL PURPOSE COST CENTER		520	2,477,3	20	
3. 00 11300 I NTEREST EXPENSE					113.
8.00 SUBTOTALS (SUM OF LIN	ES 1 through 117) 115, 395,	755	0 115, 395, 7	55	118.
NONREI MBURSABLE COST CENTER		1	1		
D. 00 19000 GIFT, FLOWER, COFFEE			0 208, 5	07	190.
2. 00 19200 PHYSI CI ANS' PRI VATE 0		-	0 75 4	0	192.
2. 02 19202 VI SI TOR MEALS 2. 03 19203 GREAT BEGI NNI NGS/MATE	75, PNAL 180		0 75,4		192. 192.
2. 03 19203 GREAT BEGINNINGS/MATE 2. 04 19204 LIFELINE	RNAL 180,	0	0 180, 7 0	28	192.
2. 05 19205 OWNED PROPERTIES	112,	-	0 112, 2	-	192.
2. 06 19206 UROLOGY	1, 920,		0 1, 920, 3		192
2. 08 19211 PARI SH NURSI NG		721	0 84, 7		192.
2. 09 19212 BI OTERRORI SM GRANT	57,	422	0 57, 4	22	192
2. 10 19214 BREAST PUMPS		0	0	0	192.
2. 12 19209 LUNG CENTER	835,		0 835, 1		192.
2. 14 19210 MGH PHYS PRACT MGMT 2. 15 19215 MGH MARION SURGEONS	2, 235, 3, 097,		0 2, 235, 2 0 3, 097, 2		192. 192.
2. 16 19216 MGH MARTON SURGEONS 2. 16 19216 MGH MGH MED ONC	3,097, 1,699,		0 3,097,2		192.
2. 17 19217 MGH FMC SOUTH	4,060,		0 4,060,7		192
2. 18 19218 MGH FAI RM MED ASSOC	4, 000, 437,		0 437, 4		192.
2. 19 19219 MGH FMC MARION	1, 019,		0 1, 019, 9		192
3. 00 19300 NONPAID WORKERS	.,,	о	0	0	193.
3.01 19301 MGH FMC NORTHWOOD	1, 702,	665	0 1, 702, 6	65	193.
3.02 19302 MGH FMC GAS CITY	1, 086,		0 1, 086, 5		193.
3. 03 19303 MGH HOSPI TALI STS	4, 791,	357	0 4, 791, 3	57	193.
3. 04 19304 MGH MAR FAM PRACT	3, 946,		0 3, 946, 6	10	193.

Health Financial Systems	MARION GENERA	AL HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/26/2018 2:38 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00	_	
193.0519305 MGH FMC SWAYZEE	357, 133		357, 1	33	193.05
193.06 19306 MGH PEDIATRIC CTR	1, 492, 866	0	1, 492, 8		193.06
193.07 19307 MGH SPECIALTY PHYS	417, 295	0	417, 2		193.07
193.08 19308 MGH FMC CONVERSE	460, 192	0	460, 1	92	193.08
193.09 19309 MGH UPLAND HEALTH	2, 239, 576	0	2, 239, 5	76	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	193. 10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0	193. 11
193. 12 19312 OB/GYN	3, 505, 520	0	3, 505, 5	20	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	193. 15
194.0007963 HEART FAILURE CLINIC	32, 200	0	32, 2	00	194.00
194. 01 07950 MOW	125, 434	0	125, 4	34	194. 01
194.0207951 MENTAL HEALTH	134, 641	0	134, 6	41	194.02
194. 03 07952 ADVERTI SI NG	387, 865	0	387, 8	55	194. 03
194.0407953 MGH WORK SOLUTIONS	1, 033, 573	0	1, 033, 5	73	194.04
194.0507954 MGH TAYLOR UNIVERSITY	174, 149	0	174, 1	19	194. 05
194.0807957 MGH SMMP BLDG	292, 543	0	292, 5	13	194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0	194. 09
194.1007959 MGH 106 LYONS BLDG	7, 219	0	7,2	19	194. 10
194. 11 07960 FAI RMOUNT	29, 108	0	29, 1	08	194. 11
194. 12 07961 GAS_CLTY	0	0		0	194. 12
194. 13 07962 LYONS	0	0		0	194. 13
194. 14 07964 WABASH	1, 963	0	1, 9	53	194. 14
194.1507965 TOBACCO GRANT	55, 602	0	55, 6	02	194. 15
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118 through 201)	153, 694, 610	0	153, 694, 6	10	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	MARION GENERA	AL HOSPITAL Provider CO		In Lie eriod: com 07/01/2017	u of Form CMS-: Worksheet B Part II	2552-10
				To			pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
			1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1		I		Γ	
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	474, 349 2, 055, 876		474, 349 87, 195 0		1.00 4.00 5.00 6.00
6. 01 6. 02	00601 CAFETERIA 00602 CAFETERIA	0	165, 321 0	165, 321 0	0	23, 880 0	6. 01
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	3, 336, 917 71, 922	3, 336, 917 71, 922	6, 155 0		
9.00 10.00	00900 HOUSEKEEPING 01000 DI ETARY	0	110, 963 227, 780	110, 963	0	45, 013 12, 331	9.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	23, 690 81, 112	23, 690	9, 364 1, 167	21, 573 8, 281	•
	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	104, 496		27, 286	1	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	1, 470, 360 341, 058		67, 829 20, 285	60, 356	31.00
40.00 41.00 42.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0 326, 251 0	0 326, 251 0	0 10, 057	0 37, 543 0	
	04200 JURSERY ANCI LLARY SERVICE COST CENTERS	0	0	0	9, 429		•
50. 00 51. 00	05500 OPERATI NG ROOM 05100 RECOVERY ROOM	0	1, 172, 700 0	1, 172, 700 0	0	222, 713 0	50.00 51.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	704, 103 51, 227	704, 103 51, 227	24, 187 5, 327	101, 090 20, 599	54.00
58.00 59.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	60, 723 171, 550		2, 586 6, 595		•
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY	0	445, 757 0	445, 757 0	23, 049 10, 091	31, 284	60. 01
60. 02 65. 00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	0	0 151, 638		0 13, 608		•
66. 00 69. 00 69. 01	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	29, 987 270, 736 44, 147	29, 987 270, 736 44, 147	16, 316 8, 365 1, 586	24, 601	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	44, 147	44, 147	1, 566 0 0	4,000	1
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	-	
	09000 CLI NI C	0	, 0, 0, 0		2, 997		
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	376, 831	376, 831 0	40, 027		92.00
	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		141, 256	141, 256	11, 459	28 420	92.01 95.00
	SPECIAL PURPOSE COST CENTERS	-	,===	, ====			
113.00 118.00		0	12, 507, 145	12, 507, 145	404, 960	1, 623, 773	113. 00 118. 00
	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0	45, 236	45, 236	339		190. 00 192. 00
192.02	19202 VI SI TOR MEALS 19203 GREAT BEGI NNI NGS/MATERNAL	0	0	0	0 1, 019	0	192.02 192.02 192.03
192.04	19204 LI FELI NE 19205 OWNED PROPERTI ES	0	0	0	0	0	192. 04 192. 05
192.08	19206 UROLOGY 19211 PARI SH NURSI NG	0	0 0	0 0	3, 451 356	1, 067	192. 06 192. 08
192.10	19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS	0	0	0 0	301 0	0	192. 09 192. 10
192.14	19209 LUNG CENTER 19210 MGH PHYS PRACT MGMT	0	0	0	1, 174 10, 109	29, 984	192.12 192.14
192.16	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	0	0	0	5, 252 0 7, 602	23, 700	192. 16
192.18	19218 MGH FAIRM MED ASSOC 19219 MGH FAIRM MED ASSOC	0		0	7, 802 1, 013 2, 728	6, 098	192. 17 192. 18 192. 19
193.00	19300 NONPAI D WORKERS 19301 MGH FMC NORTHWOOD		0	0	2,723 0 3,343	0	193. 00 193. 01
	19302 MGH FMC GAS CITY 19303 MGH HOSPITALISTS	0	0	0 0	2, 345 376		193. 02 193. 03

Health Financial Systems	MARION GENER	AL HOSPI TAL			In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	_	Provider CC	N: 15-0011		riod: om 07/01/2017 06/30/2018	Worksheet B Part II Date/Time Pre 11/26/2018 2:	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal		BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
	0	1.00	2A		4.00	5.00	
193.04 19304 MGH MAR FAM PRACT	0	0		0	9, 639	54, 511	•
193.05 19305 MGH_FMC_SWAYZEE	0	0		0	783		193. 05
193.06 19306 MGH PEDIATRIC CTR	0	0		0	2, 473		193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0	826		193. 07
193.08 19308 MGH FMC CONVERSE	0	0		0	1, 085		193. 08
193.09 19309 MGH UPLAND HEALTH	0	0		0	4, 363	30, 528	
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	5, 387	47, 626	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	0	0	193.15
194.00 07963 HEART FAILURE CLINIC	0	0		0	0	449	194.00
194.0107950 MOW	0	0		0	0	0	194.01
194.0207951 MENTAL HEALTH	0	0		0	0	0	194.02
194. 03 07952 ADVERTI SI NG	0	0		0	1, 810	5, 310	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0		0	3, 079	13, 954	194.04
194.0507954 MGH TAYLOR UNIVERSITY	0	0		0	308	2, 428	194.05
194.0807957 MGH SMMP BLDG	0	0		0	0	4,079	194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0	0	0	194.09
194.1007959 MGH 106 LYONS BLDG	0	0		0	0	101	194.10
194. 11 07960 FAI RMOUNT	0	0		0	o	406	194.11
194. 12 07961 GAS CITY	0	0		0	o	0	194.12
194. 13 07962 LYONS	0	0		0	o	0	194.13
194, 14 07964 WABASH	0	0		0	0		194, 14
194. 15 07965 TOBACCO GRANT	0	0		0	228		194.15
200.00 Cross Foot Adjustments				0			200.00
201.00 Negative Cost Centers		0		0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	12, 552, 381	12, 552, 3	381	474, 349	2, 143, 071	•

ALLOCATION OF CAPT ALL RELATED DISTS IPPOID Description Description <thdescription< th=""> <thdesc< th=""><th>Health Financial Systems</th><th>MARION GENERAL</th><th>HOSPI TAL</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></thdesc<></thdescription<>	Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
In Dev //UUUND Dev //UUUND <thdev th="" uuund<=""> <thdev< td=""><td></td><td></td><td></td><td></td><td>eriod:</td><td>Worksheet B</td><td></td></thdev<></thdev>					eriod:	Worksheet B	
Cost Cantor Discription MM (Number) CAPE LEMA						Date/Time Pre	pared:
Balance Secure Coord Double A FLY 6.01 6.01 6.01 6.02 7.00 9.00 100 00000 ENF REP. CONT. DEPARTNEWT 100	Cost Center Description		CAFETERIA	CAFETERI A		LAUNDRY &	
Different STRN OF CONT CENTERS Image: Content Centers Image: Content Centers Image:			6.01	6.02			
4.00 DOUDD (PERSITY INTENTION TO A CALLED A CONTROL OF A	GENERAL SERVICE COST CENTERS	0.00	0.01	0.02	7.00	0.00	
5.00 00000 AVMINISTRUP & GENERAL 6.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
0.00 00000 MAINTENANCE & SEPARES 0 180,071							
6.02 DOSC/ DECOMPATION OF HART 0 110, 071 310, 072 6.02 0.0000 DECOMPATION OF HART 0 <		0					
1.00 DOUDD DELEMINGY LINE 0 4.415 3.424,223 116,642 8.0 9.00 DOUDD LINENTY LINE C 0 38,33 116,642 8.0 9.00 0.0 39,344 0 10.0 0.0 10.0 0.0 10.0 0.0 10.0 0.0 10.0		0		100.074			
8.00 00300 LAUNDRY SERVICE 0		0			3, 492, 925		
10.00 01000 0122.02 0 10.00 0000 0122.02 0 10.00 10.00 0000 01.00		0	Ő			118, 694	
13.00 13.00		0	0	-			
14.00 0 0 0 0 0 0 0 0 0 0 1 0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>		0	0	0			
INPART ENT ROUTINE SERVICE COST CENTERS 0		0	-				
98.000 03000 JADULTS & HEDLATRICS 0 03002 JADULTS & HEDLATRICS 0 0 30.00		0	0	9, 174	55, 982	0	15.00
11. 00 010000 010000 0100000 01000000 0100000000 0100000000000000000000000000000000000		0	0	30 824	787 719	29.033	30.00
11.00 01100 SUBPRIVU DER - I RE 0 0 4.300 0 </td <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td>		1					
42 00 00 00 0 0 0 0 0 0 0 1 43 00 AUXILLARY SERVICE COST CENTERS 0 0 24.605 628.952 21.022 50.00 54 00 005000 (FRAIT IR, ROW 0 0 24.605 628.952 21.022 50.00 54 00 005400 (EXDICADY-0I ARINGTIC 0 0 12.532 377.121 8.600 54.00 58.00 05600 (MARHTIC RESONANCE IMAGE IN (MRI) 0 0 3.048 91.00 55.00 55.00 55.00 56.00 <t< td=""><td></td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td></t<>		0	0	0			
43.00 0 43200 NURSERY 0		-	8	4, 394			
60.00 05000 (DFERTING ROOM 0 0 24.605 628.752 21.022 50.00 0 <td></td> <td>-</td> <td>-</td> <td>3, 895</td> <td></td> <td></td> <td></td>		-	-	3, 895			
151.00 05100 RECOVERY ROM 0 0 1 0 0 0 0 0 0 51.00 0 0 0 0 0 0 0 0 0 0 0 0 1.00 0 1.00 0 0 1.00 0			-				
54.00 0F400 RADIOLOCY-DLAGNOSTIC 0 0 1.5.32 377.210 8.460 54.00 55.00 0F300 CT SCAN 0 0 2.697 27.444 3.405 57.00 58.00 05800 MAGNET C RESONANCE LINGING (NRI) 0 0 3.048 91.905 1.005 59.00 05900 CARDIA CATHERERIZATION 0 0 1.749 238.806 1 60.00 0.00 06000 LABORATONY 0 0 1.749 238.806 1 60.00 0.00 06000 CRADIA CATHERERIZATION COCY 0 0 0 7.60 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 70.00 60.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00			-				
B8 00 GSB00 MARCH TIC RESONANCE LIMICA ING (MR1) 0 0 6655 32,531 0 88 00 60 00 CARDIA, CATHERERIZATION 0 0 3,048 91,905 1,402 59,000 60,00 0		0	0	0	-		
99 00 05500 CARDLAC CATHETERIZATION 0 0 3, 0.48 91, 905 1, 402 90 00 60 0 <td< td=""><td></td><td>0</td><td>°,</td><td></td><td></td><td></td><td></td></td<>		0	°,				
60.00 06000 LABORATORY 0 0 11, 749 238, 806 1 60.00 60.01 OGOD ONCLOCY 0		0	°,				
0 0 0 0 0 0 712 60.01 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
65.00 00500 PESPI RATORY THERAPY 0 0 5.755 81.237 715 65.00 60.00 06900 PHYSI CAL THERAPY 0 0 2.382 66.00 60.00 06900 LCTROCARDIOLOGY 0 0 4.497 145.042 871 69.00 60.00 0 0 767 23.651 0 90.00 73.00 72.00 720.00 PATLENT SERVICE COST CENTERS 0 0 0 73.00 00.00 0.00 0 1.269 51.642 53.80 90.00 01.00 0.00 0 1.269 51.642 53.80 90.00 02.01 0.00 0 0 1.269 51.642 53.80 90.00 92.00 90.00 0.00 0 0 0 0 0 0 92.00 90.00 0.00 0 0 0 0 0 0 0 0 0 0		0	0			712	
66.00 0e600 PHYSICAL THERAPY 0 0 2,717 16,065 2,382 66,00 69.00 0e900 LECTROCADD LOCGY 0 0 4,497 145,042 871 69,00 69,00 69,00 69,00 69,00 69,00 69,00 69,00 69,00 69,00 0		0	0	0	0 01 027		
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17.1 00 07100 MD10CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 072001 NPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 00 0730.00 RUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 00 00000 CLIN C 0 0 1.269 51.642 538 90.00 92.00 92.00 0 0 0 92.01 92.0	69. 00 06900 ELECTROCARDI OLOGY	0	0	4, 497	145, 042		69.00
12.00 07200 IMPL DEV. CHARGED TO PATIENTS 0		0	0				
73.00 OX300 DRUGS CHARGED TO PATIENTS O O O O 73.00 90.00 OUTPATIENT SERVICE COST CENTERS 0 0 1,269 51,642 538 90.00 91.00 DRUGENREENCY 0 0 18,757 201,880 34,365 91.00 92		0	0	0	-		
90.00 00000 CLINIC 0 1,269 51,642 538 90.00 91.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.01 0055874110N BEDS (NISTINCT PART) 0 0 0 0 0 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.00 92.00 92.00 92.00 92.00	73.00 07300 DRUGS CHARGED TO PATIENTS		0	0	0		
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92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 </td <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>			-				
OTHER REI MOUSABLE COST CENTERS O O G, 900 75, 675 4, 277 95.00 SPECIAL PURPOSE COST CENTERS 0 0 6, 900 75, 675 4, 277 95.00 113.00 INTEREST EXPENSE 0 0 6, 900 75, 675 4, 277 95.00 100.00 SUBTOTALS SUM OF LINES 1 through 117) 0 180, 871 160, 533 3, 468, 691 118, 253 118.00 100.00 19200 IPSOLGANS RIVATE OFFICES 0 0 141 24, 234 0 190.00 192.00 IPSOLO PHYSICIANS INATE REGINNINSS/MATERNAL 0 0 0 0 0 192.02 192.04 IPSOLO GWED ROPERTIES 0 0 0 0 0 0 192.05 192.06 UROLOGY 0 0 2, 565 0 0 192.02 192.02 192.02 192.02 192.02 192.02			_	,		,	
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SPECIAL PURPOSE COST CENTERS 113.00 11300 11200 11200 11200 11200 11200 11200 11200 11200 11200 11200 11200 11200 </td <td></td> <td>0</td> <td>0</td> <td>6, 900</td> <td>75, 675</td> <td>4, 277</td> <td>95.00</td>		0	0	6, 900	75, 675	4, 277	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 180.871 160,533 3,468,691 118,253 118.00 NORE IMBURSABLE COST CENTERS 0 0 141 24,234 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFIC ES 0 0 0 192.00 192.02 19203 GREAT BEGI NNI NOS/MATERNAL 0 0 0 192.03 192.04 19204 UI SI TOR MEALS 0 0 0 0 192.03 192.05 WINED ROPERTIES 0 0 0 0 192.06 192.06 19205 WINED ROPERTIES 0 0 0 192.06 192.06 19212 BIOTERORI SI GRANT 0 0 217 0 192.08 192.12 BIOTERORI SI GRANT 0 0 131 0 192.09 192.12 BIOTERORI SI GRANT 0 0 131 0 192.09 192.12 BIOTERORI SIN GRANT 0	SPECIAL PURPOSE COST CENTERS						
NORREL MBURSABLE COST CENTERS 190. 00 0 IFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 141 24, 234 0 190. 00 192. 00 19200 PIYSI CLANS' PRIVATE OFFICES 0 0 0 0 192. 00 192. 02 19202 VI SI TOR MEALS 0 8, 330 0 0 0 192. 02 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192. 04 192. 04 IPELLI NE 0 0 0 0 0 192. 05 192. 06 19205 WINDL PROPERTIES 0 0 0 192. 06 192. 06 19206 INCLOGY 0 0 217 0 192. 08 192. 08 INGRENTS ING 0 0 211 PARI SH NURSI NG 0 192. 08 192. 09 IUNG CENTER 0 0 1,087 0 192. 19 192. 10 19214 MGH PHYS PRACT MGMT 0 0 <t< td=""><td></td><td></td><td>100 071</td><td>140 522</td><td>2 469 601</td><td>110 252</td><td></td></t<>			100 071	140 522	2 469 601	110 252	
192.00 192.00 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 192.02 19203 REAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.03 192.03 19203 REAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 192.03 192.04 19204 LI FELI NE 0 0 0 0 192.02 192.05 19205 0WED PROPERTIES 0 0 0 192.06 192.06 19206 URDLOGY 0 0 2,565 0 192.08 192.09 19211 PARISH NURSI NG 0 0 1217 0 192.08 192.10 19214 BREAST PUMPS 0 0 0 0 192.12 192.11 19214 BREAST PUMPS 0 0 0 192.12 192.12 192.14 19210 UGH PHYS PRACT MGMT 0 0 0 192.12 192.12 192.14 19215 MGH MARI MS SUGEONS 0 0 0 192.14 <		0	100, 07 1	100, 555	3, 400, 091	116, 255	116.00
192. 02 192.02 VI SI TOR MEALS 0 8, 330 0 0 192.02 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.03 192. 04 19204 LI FELI NE 0 0 0 0 192.03 192. 05 19205 UWNED PROPERTI ES 0 0 0 192.05 192. 06 19206 UROLOGY 0 0 2,565 0 0 192.06 192. 08 19211 PARI SH NURSI NG 0 0 2,565 0 0 192.09 192. 08 19212 BI OTERRORI SM GRANT 0 0 131 0 0 192.09 192. 10 19214 BREAST PUMPS 0 0 0 192.10 192.12 192.09 192.10 192.12 192.09 192.12 192.12 192.10 192.12 192.10 192.12 192.10 192.12 192.10 192.12 192.12 192.12 192.12 192.12 192.12 192.12 192.12 192.12 192.12 <	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-	0				
192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 192.03 192.04 19204 LIFELI NE 0 0 0 0 192.04 192.05 19205 UNUNED PROPERTI ES 0 0 0 192.05 192.06 19206 UROLOGY 0 0 2,565 0 192.06 192.09 19211 PARISH NURSI NG 0 0 217 0 192.08 192.09 19212 BI OTERRORI SM GRANT 0 0 192.09 192.09 192.09 192.09 192.09 192.09 192.09 192.10 0 192.09 192.01 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19 192.19<		0	0	0	0		
192.05 19205 OWNED PROPERTIES 0 0 0 192.05 192.06 19206 UROLOGY 0 0 2,565 0 0 192.06 192.08 19211 PARISH NURSING 0 0 217 0 0 192.09 192.09 19212 BIOTERRORISM GRANT 0 0 131 0 192.09 192.12 IDTERRORISM GRANT 0 0 0 192.09 192.12 101214 BREAST PUMPS 0 0 192.12 0 192.12 10 192.14 192.09 192.12 102.09 192.12 192.09 192.15 192.15 192.15 192.15 192.15 192.15 192.15 192.15 192.16 0 0 192.16 192.17 192.15 MGH FMC SOUTH 0 0 0 0 192.17 192.18 192.19 MGH FAIRM MED ASSOC 0 0 0 192.17 192.19 192.19 MGH FAIRM MED ASSOC 0 0 0 192.17 193.00 <td< td=""><td></td><td>0</td><td>0, 330</td><td>0</td><td>0</td><td></td><td></td></td<>		0	0, 330	0	0		
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192. 0819211PARI SH NURSI NG021700192. 08192. 0919212B I OTERRORI SM GRANT0013100192. 09192. 1019214BREAST PUMPS00000192. 10192. 1219209LUNG CENTER0000192. 12192. 1419210MGH PHYS PRACT MGMT006, 6160192. 12192. 1519215MGH MARI ON SURGEONS0000192. 15192. 1619216MGH FMC SOUTH0000192. 16192. 1719217MGH FAI RM MED ASSOC0000192. 18192. 1919219MGH FAI RM MED ASSOC0000193. 00193. 0119300NONPAI D WORKERS0000193. 00193. 0219302MGH FMC CAS CI TY0000193. 03193. 0319303MGH MAR FAM PRACT0000193. 03193. 0419304MGH MAR FAM PRACT0000193. 03193. 0519306MGH PEDI ATRI C CTR0000193. 06193. 0619306MGH PEDI ATRI C CTR0000193. 06		0	0	0	0		
192.09 19212 BI OTERRORI SM GRANT 0 131 0 192.09 192.10 19214 BREAST_PUMPS 0 0 0 0 192.10 192.12 19209 LUNG CENTER 0 0 1,087 0 192.12 192.14 19210 MGH PHYS PRACT MGMT 0 0 6,616 0 0 192.12 192.15 19215 MGH MARI ON SURGEONS 0 0 3,794 0 0 192.16 192.16 19216 MGH MED ONC 0 0 0 0 192.17 192.18 19218 MGH FMC SOUTH 0 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 0 0 192.18 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.01 193.02 19303 MGH FMC NORTHWOOD 0 0 0 0 193.03 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>		0	0		0		
192.12 19209 LUNG CENTER 0 0 1,087 0 0 192.12 192.14 19210 MGH PHYS PRACT MGMT 0 0 6,616 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 3,794 0 0 192.15 192.16 19216 MGH MGH MED ONC 0 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 192.16 192.18 19219 MGH FAI RM MED ASSOC 0 0 0 192.18 192.19 19219 MGH FMC NARI ON 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.01 193.01 19301 MGH FMC GAS CITY 0 0 0 0 193.02 193.02 19302 MGH MAR FAM PRACT 0 0 0 193.03 193.03 19303 MGH HOSPI TALI STS 0 0 0 193.03 193.04 <td>192. 09 19212 BI OTERRORI SM GRANT</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>192.09</td>	192. 09 19212 BI OTERRORI SM GRANT	0	0		0	0	192.09
192. 14 19210 MGH PHYS PRACT MGMT 0 0 192. 14 192. 15 19215 MGH MARI ON SURGEONS 0 0 3, 794 0 0 192. 15 192. 16 19216 MGH MGH MED ONC 0 0 0 0 192. 16 192. 17 19217 MGH FAI RM SOUTH 0 0 0 49 192. 17 192. 18 INGH FAI RM MED ASSOC 0 0 0 192. 18 192. 19 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 18 192. 19 192. 18 192. 18 192. 19 192. 19 192. 19 192. 19 192. 19 192. 19 192. 19 192. 19 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
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192.1719217MGHFMCSOUTH0049192.17192.1819218MGHFAI RMMEDASSOC00013192.18192.1919219MGHFMCMARI ON0002,28000192.19193.0019300NONPAI DWORKERS00000193.00193.0119301MGHFMCNORTHWOOD000193.01193.0219302MGHFMC GAS CI TY0000193.02193.0319303MGHHOSPI TALI STS0000193.02193.0419304MGHMAR FAM PRACT0000193.04193.0519305MGHFMC SWAYZEE0000193.05193.0619306MGHPEDI ATRI C CTR0002,04904	192.15 19215 MGH MARION SURGEONS	0	0			0	192. 15
192.18 MGH FAI RM MED ASSOC 0 0 0 13 192.18 192.19 MGH FMC MARI ON 0 0 2,280 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 0 0 193.01 193.02 19302 MGH FMC GAS CI TY 0 0 0 0 193.02 193.03 19303 MGH HOSPI TALI STS 0 0 0 193.03 193.04 19304 MGH MAR FAM PRACT 0 0 0 193.04 193.04 19305 MGH HOSPI TALI STS 0 0 0 193.04 193.04 19305 MGH FMC SWAYZEE 0 0 0 0 193.05 193.06 19306 MGH PEDI ATRIC CTR 0 0 2,049 4 193.06		0	0	0	0		
192.19 MGH FMC MARI ON 0 0 2,280 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 193.01 19301 MGH FMC NORTHWOOD 0 0 0 0 193.01 193.02 19302 MGH FMC GAS CI TY 0 0 0 0 31 193.02 193.03 19303 MGH HOSPI TALI STS 0 0 0 0 193.03 193.04 19304 MGH MAR FAM PRACT 0 0 0 99 193.03 193.05 19305 MGH FMC SWAYZEE 0 0 0 0 193.05 193.06 19306 MGH PEDI ATRI C CTR 0 0 2,049 0 4 193.06		0	0	0	0		
193.01 I9301 MGH FMC NORTHWOOD 0 0 193.01 193.02 19302 MGH FMC GAS CITY 0 0 0 31 193.02 193.03 19303 MGH HOSPI TALI STS 0 0 0 0 193.03 193.04 19304 MGH MAR FAM PRACT 0 0 0 0 99 193.04 193.05 19305 MGH FMC SWAYZEE 0 0 0 0 193.05 193.06 19306 MGH PEDIATRIC CTR 0 0 2,049 0 4 193.06		0	0	2, 280	0	0	192. 19
193.02 MGH FMC GAS CITY 0 0 0 31 193.02 193.03 19303 MGH HOSPITALISTS 0 0 0 0 193.03 193.04 19304 MGH MAR FAM PRACT 0 0 0 0 99 193.04 193.05 19305 MGH FMC SWAYZEE 0 0 0 0 193.05 193.06 19306 MGH PEDIATRIC CTR 0 0 2,049 0 4 193.06		0	0	0	0		
193.03 MGH HOSPI TALI STS 0 0 0 193.03 193.04 19304 MGH MAR FAM PRACT 0 0 0 99 193.04 193.05 19305 MGH FMC SWAYZEE 0 0 0 0 193.05 193.06 19306 MGH PEDIATRIC CTR 0 0 2,049 0 4 193.06		0	0	0	0		
193.05 MGH FMC SWAYZEE 0 0 0 0 193.05 193.06 19306 MGH PEDIATRIC CTR 0 0 2,049 0 4 193.06	193. 03 19303 MGH HOSPI TALI STS	0	0	0	0	0	193. 03
193.06 19306 MGH PEDIATRIC CTR 0 0 2,049 0 4 193.06		0	0	0	0		•
			0	0 2.049	0		
		0	0				

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 07/01/2017 To 06/30/2018		pared: 38 pm
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS 6, 00	6. 01	6. 02	PLANT 7.00	LINEN SERVICE 8.00	
193.08 19308 MGH FMC CONVERSE	0.00	0.01	0.02	0 0		193.08
193. 09 19309 MGH UPLAND HEALTH	0	0		0 0		193.09
193. 10 19310 MGH MGH WOMENS CTR	0	0		0 0		193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0 0	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
194.0007963 HEART FAILURE CLINIC	0	0		0 0	0	194.00
194. 01 07950 MOW	0	0		0 0	0	194. 01
194.0207951 MENTAL HEALTH	0	0		0 0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	78	1 0	0	194. 03
194.0407953 MGH WORK SOLUTIONS	0	0		0 0	20	194.04
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0		0 0	0	194. 05
194.0807957 MGH SMMP BLDG	0	0		0 0		194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0		194.09
194.1007959 MGH 106 LYONS BLDG	0	0		0 0		194. 10
194. 11 07960 FAI RMOUNT	0	0		0 0		194. 11
194. 12 07961 GAS CI TY	0	0		0 0		194. 12
194. 13 07962 LYONS	0	0		0 0		194. 13
194. 14 07964 WABASH	0	0		0 0		194.14
194. 15 07965 TOBACCO GRANT	0	0	9	3 0		194. 15
200.00 Cross Foot Adjustments		_				200.00
201.00 Negative Cost Centers	0	0	100.07	0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	189, 201	180, 87	3, 492, 925	118, 694	202.00

PLICATION DF CAPITAL RELATED COSTS Provider CCR: 15-0011 Perror Brit II From 62/20120 are 31 bit III TARY Perror Brit III Perror Brit III Sciences A Status A Statu	Heal th !	Financial Systems	MARION GENERAL	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
Total Discreting (Processing) Discreting (Processing) Discreting (Processing) Cost Center Description HOUSEXCEPTING District (Processing) Discreting (Processing) Photocol (Processing) 1 Discreting (Processing) 0.00 10.00 13.00 14.00 15.00 1 Discreting (Processing) 0.00 10.00 13.00 14.00 15.00 1 Discreting (Processing) 0.00 10.00 13.00 14.00 15.00 1 Discreting (Processing) 0.00 10.00 13.00 14.00 14.00 15.00 0 Discreting (Processing) 0.00 10.00 14.1152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.00 20.00 14.1.152 20.						eriod:	Worksheet B	
Cost Contor Description HUSERCEPINS MULTISTATION DIETARY MULTISTATION CENTRAL MULTISTATION PHARMACY MULTISTATION 1000 00100 (HN CAP HLL COST CENTERS 9.00 10.00 13.00 14.00 1000 00100 (HN CAP HLL COSTS-BLO & FLIX I 4.00 (CARCE MULTISTE DEPARTMENT 5.00 (COSO (AMULTISTATIVE & CEREBAL 6.01 (COSO) (CAPETERIA 6.01 (COSO) (COSO) (CAPETERIA 6.01 (COSO) (COSO) (COSO) (COSO) (COSO) 6.00 (COSO) (CPEATIA 6.01 (COSO) (COSO) (CPEATIA 6.01 (COSO) (COS							Date/Time Pre	pared:
EVENAL SERVICE COST CENTERS 0 10.00 13.00 14.00 15.00 1 0 00000 HEBI CAPTERE COSTS FLICS A FIXT 10.00 13.00 14.00 15.00 0 00000 HEBI CAPTERE COSTS FLICS A FIXT 0 0.00		Cost Center Description	HOUSEKEEPING	DI ETARY				<u>38 pm</u>
CHURAL SERVICE COST CENTERS 100 00100 (BMC GAP REL COSTS-BLDG & 11X1 4.00 00400 (BMC GAP REL COSTS-BLDG & 11X1 5.00 00500 (BMC STR-LIS & GENERAL 6.01 00200 (BMC STR-LIS & GENERAL 6.02 00200 (BMC STR-LIS & GENERAL 6.01 00200 (BAN STRATUS & GENERAL 6.02 00200 (CHURC) COST CENTERS 7.00 00700 (PERATION OF PLANT 8.00 00800 (DTEAW) 9.01 001300 (BTEAW) 9.02 0 9.03 0 0.01 00100 (SUBPRWOUDER - IFF 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 0.01 <td></td> <td></td> <td></td> <td>10.00</td> <td></td> <td>SUPPLY</td> <td>45.00</td> <td></td>				10.00		SUPPLY	45.00	
1.00 0100 PME/CAR PELL COSTS-BLDG & FLYT 4.00 00500 ADMIN STRATIVE & GENERAL 6.01 00600 ADMIN STRATIVE & SUPPLY 4.955 0.01 1.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00 0.0000 ADMINS & LINON SERVICE 9.00 0.0000 ADMINS & LINON SERVICE 9.00 1.00	C	GENERAL SERVICE COST CENTERS	9.00	10.00	13.00	14.00	15.00	
5. 00 00500 ADM IN STRATI VE & GENERAL 6. 00 00601 CAFETERIA 6. 01 00700 OPERATION OF PLANT 6. 01 007000 DETARY 10. 00 0000000 DETARY 10. 00 01400 CENTRAL SERVICES & SUPPLY 4. 00 01400 CENTRAL SERVICES OST CENTERS 00. 00300 DHUTS & PERANCY 2.775 00. 00300 DHUTS & PERANCY 2.755 00. 00300 DHUTS & PERANCY 2.755 00. 03100 HINENS KOMUTS COST CENTERS 7.869 00. 03100 HINESKY MOLTON FILL 2.681 11. 000 DUTS & PERANTINS COST CENTERS 0 00. 03100 HINESKY MOLTON FILL 2.840 0. 03100 HINESKY MOLTON 29.31 0. 04200 BURSKY MOLTON 29.31 0. 04200 BURSKY MOLTON 29.31 0. 05100 RECOVERY MOM 29.31 0. 05100 RECOVERY MOM <	1.00	DO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
6. 00 00000 MAINTERNANCE & REPAIRS								4.00
6 01 00601 CAFETERIA 6 00700 OPERATION OF PLANT 7 7 0 0 0 0 0 141, 152 270, 970 0 00700 OPERATION OF PLANT 7 3 0, 55, 311 7 1, 027 0 0 0 0 0 141, 152 270, 970 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								5.00 6.00
7. 00 0070C GPERATI ON OF PLANT 00 0000C LANDRY & LINNER SERVICE 01 9. 00 0090C HAUSKELEPI NG 215,422 0.10 0100C GUTRAL SERVICES & SUPPLY 2,15,422 13. 00 01300 NURSING AMIN ISTRATION 991 0 71,027 141,152 220,070 0150C PARABACY CENTRAL SERVICES & SUPPLY 2,075 0								6. 01
0.00 000000 LAUMORY & LINEN SERVICE 215, 422 10.00 01000 DI ETARY 3, 171 365, 311 11.00 01400 CENTRAY 3, 171 365, 311 11.00 01400 CENTRAL SERVICES & SUPPLY 4, 955 0 0 0 11.00 01400 CENTRAL SERVICE S & SUPPLY 4, 955 0 0 0 270, 970 INPATIENT ROUTINE SERVICE COST CENTERS 45, 978 218, 929 18, 836 19, 759 0 0 0 0.00 03000 DITATENSIVE CARE UNIT 12, 664 37, 659 5, 156 4, 940 0 0.01 0.0100 SUBPROVIDER 11, 078 0 0 2, 881 0 0 0.01200 DEFAATING ROM 20, 331 0 15, 037 8, 469 0								6. 02
9 000000000000000000000000000000000000								7.00
10.00 01000 DILETARY 5.171 365,311 71,027 14.00 01400 CENTRAL SERVICES & SUPPLY 4.955 0 0 0 270,970 14.00 01400 CENTRAL SERVICES & SUPPLY 4.955 0 0 0 270,970 10.00 00000 Automation 5.976 218,929 18,836 19,759 0			215, 422					9.00
14.00 01400 CENTREL SERVICES & SUPPLY 4.955 0 141,152 15.00 01500 PHARMACY 2.775 0 0 141,152 100 03000 INPATIENT ROUTINE SERVICE COST CENTERS	10.00	D1000 DI ETARY	3, 171	365, 311				10.00
15.00 01500 PHARMACY 2.775 0 0 0 270.970 10.00 03000 AULTS & PEDIATRICS 45,978 218,929 18,836 19,759 0						141 150		13.00
INPATI ENT ROUTI NE SERVICE COST CENTERS 00 03000 AULTS & PEDIATRICS 45.978 218.929 18.836 19.759 0 31.00 03000 INTENSIVE CARE UNIT 12.6484 37.659 5.158 4.940 0 41.00 04000 SUBPROVIDER - IFF 0 0 0 0 0 0 0 42.00 04200 SUBPROVIDER - IFF 0 <							270 970	14.00 15.00
131 00 03100 INTERSIVE CARE_UNIT 12,684 37,659 5,158 4,940 0 0400 04000 SUBPROVIDER - IPF 0 <t< td=""><td></td><td></td><td>2,110</td><td></td><td></td><td>3</td><td>2707770</td><td>10100</td></t<>			2,110			3	2707770	10100
40.00 0 0 0 0 0 0 0 0 41.00 04000 SUBPROVIDER 1 RF 11.098 31.077 2.685 1.412 0 42.00 OLOS SUBPROVIDER 0 0 2.381 0 0 0 0 43.00 OLOS OVERATING ROM 29.331 0 15.037 8.469 0 0 51.00 05000 OPERATING ROM 29.331 0 15.037 8.469 0								
41.00 04100 SUBPROVIDER 11.098 31.077 2.685 1.412 0 42.00 04200 NURSERY 0 0 0 0 0 0 0 43.00 04300 NURSERY 0 0 2,381 0 0 0 50.00 05000 OPERATING ROM 29.331 0 15.037 8.469 0<			12,684					
43.00 Odsol NURSERY O O 2, 381 O O ANCILLARY SERVICE COST CENTERS 50.00 OPERATI NO. ROOM 29, 331 0 15, 037 8, 469 0 51.00 OSTOOD RECOVERY ROOM 0			11, 098		-	-		
ANCI LLARY SERVICE COST CENTERS 29,331 0 15,037 8,469 0 50.00 05000 OPERATINOR ROM 29,331 0 15,037 8,469 0 51.00 05000 RADIOLOGY-DIAGNOSTIC 13,080 0 0 4,235 0 57.00 05700 CT SCAN 595 0 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>			-					
50:00 OPERATING ROOM 29, 331 0 15, 037 8, 469 0 51:00 OST000 REDUEYPROM 0			0	C	2, 381	0	0	43.00
54:00 CASHO CASHO <td< td=""><td></td><td></td><td>29, 331</td><td>C</td><td>15, 037</td><td>8, 469</td><td>0</td><td>50.00</td></td<>			29, 331	C	15, 037	8, 469	0	50.00
57.00 05700 CT SCAN 595 0 0 0 0 58.00 05800 MCRETIC RESONANCE I MAGING (MRI) 3,964 0 1,863 5,646 0 60.00 06000 LABORATORY 11,098 0 8,469 0 60.01 06001 OCOLOGY 0			-	C		-		
58.00 OSS00 MAGNETIC RESONANCE IMAGING (MRI) 0				C	-			
59.00 OS900 CARDI AC CATHETERI ZATI ON 3, 964 0 1, 863 5, 646 0 60.00 OG000 LABORATORY 11, 098 0				C	Ű	-		
60.01 00001 0000LOCLOGY 0	59.00	05900 CARDI AC CATHETERI ZATI ON		C			-	59.00
60.02 06002 RADI ATI ON ONCOLOGY 0				C				
65.00 06500 RESPI RATORY THERAPY 8, 324 0 3, 407 7, 763 0 66.00 06600 PHYSI CAL THERAPY 0 0 1, 660 0 0 69.00 06900 ELECTROCARDI OLOGY 5, 351 0 2, 748 3, 529 0 69.01 06901 CARDI AC REHAB 5, 945 0 469 0 0 71.00 MDI CAL SUPPLIES CHARGED TO PATIENTS 0<				C	-		-	60. 01 60. 02
69.00 06900 ELECTROCARDIOLOGY 5, 351 0 2, 748 3, 529 0 69.01 06901 CARDIAC REHAB 5, 945 0 469 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0			8, 324	C	-	-		
69.01 06901 CARDIAC REHAB 5,945 0 469 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 <			U U	C		-		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
73.00 OT300 DRUGS CHARGED TO PATIENTS 0 0 270,970 0UTPATIENT SERVICE COST CENTERS				C				
OUTPATI ENT SERVICE COST CENTERS 90.00 O90000 CLINIC 3,964 0 776 0 0 91.00 O9100 EMERGENCY 47,561 4,574 11,463 4,940 0 92.00 O9200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0 0 92.01 O9201 OBSERVATI ON BEDS (DI STINCT PART) 0			-			-	-	72.00
90.00 09000 CLINIC 3,964 0 776 0	-			(0	U	270, 970	73.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 07100 OTHER REI MBURSABLE COST CENTERS 0 4, 217 1, 412 0 95.00 09500 AMBULANCE SERVICES 1, 387 0 4, 217 1, 412 0 95.01 113.00 INTEREST EXPENSE 5UBTOTALS (SUM OF LINES 1 through 117) 212, 252 292, 239 70, 700 71, 280 270, 970 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212, 252 292, 239 70, 700 71, 280 270, 970 190.00 192000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 396 0 0 0 0 192.02 19202 VI SI TOR MEALS 0 0 0 0 0 0 0 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 0 0 192.04 19204 LI FELI NE 0 0 0 0 0 0<	90.00	09000 CLI NI C		-			0	90.00
92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0			47, 561	4, 574	11, 463	4, 940	0	
OTHER REIMBURSABLE COST CENTERS 95.00 OP500 AMBULANCE SERVICES 1,387 0 4,217 1,412 0 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 1 <td></td> <td></td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>0</td> <td>92.00 92.01</td>			0	C	0	0	0	92.00 92.01
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212,252 292,239 70,700 71,280 270,970 NONREI MBURSABLE COST CENTERS NOREI MBURSABLE COST CENTERS 0 0 0 0 0 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 396 0 0 0 0 0 192.02 19202 VI SI TOR MEALS 0<						3		
113.00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 212, 252 292, 239 70, 700 71, 280 270, 970 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 396 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.01 19202 VI SI TOR MEALS 0 0 0 0 0 0 192.03 GREAT BEGI NNI NGS/MATERNAL 0 0 3277 0 0 0 192.04 19204 LI FELI NE 0 <td></td> <td></td> <td>1, 387</td> <td>С</td> <td>4, 217</td> <td>1, 412</td> <td>0</td> <td>95.00</td>			1, 387	С	4, 217	1, 412	0	95.00
Instruction SUBTOTALS (SUM OF LINES 1 through 117) 212,252 292,239 70,700 71,280 270,970 1 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 396 0								113.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 396 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.02 19202 VI SI TOR MEALS 0 0 0 0 0 0 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 327 0 0 0 192.04 19204 LI FELI NE 0			212, 252	292, 239	70, 700	71, 280	270, 970	
192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192.02 19202 VI SI TOR MEALS 0 0 0 0 0 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 327 0 0 0 192.04 19204 LI FELI NE 0 0 0 0 0 0 192.05 19205 OWNED PROPERTI ES 793 0 <t< td=""><td></td><td></td><td>20/</td><td></td><td></td><td>0</td><td></td><td>100.00</td></t<>			20/			0		100.00
192.02 19202 VI SI TOR MEALS 0 0 0 0 1 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 327 0 0 192.04 19204 LI FELI NE 0 0 0 0 0 0 192.05 19205 OWNED PROPERTIES 793 0			1					190. 00 192. 00
192.04 19204 LI FELI NE 0 0 0 0 1 192.05 19205 OWNED PROPERTIES 793 0 0 0 0 1 192.06 19206 UROLOGY 0 0 0 8,469 0 1 192.08 19211 PARI SH NURSI NG 396 0 <td< td=""><td>192.021</td><td>19202 VISITOR MEALS</td><td>0</td><td>C</td><td>0</td><td>0</td><td>0</td><td>192. 02</td></td<>	192.021	19202 VISITOR MEALS	0	C	0	0	0	192. 02
192.05 19205 OWNED PROPERTIES 793 0 0 0 1 192.06 19206 UROLOGY 0 0 0 8,469 0 1 192.08 19211 PARI SH NURSI NG 396 0 0 0 0 0 1 192.09 19212 BI OTERRORI SM GRANT 0			0	C	327	0		192.03
192.06 IP206 UROLOGY 0 8,469 0 192.08 19211 PARI SH NURSI NG 396 0 0 0 0 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 0 192.10 19214 BREAST PUMPS 0 0 0 0 0			793	C		0		192. 04 192. 05
192.09 19212 BI OTERRORI SM GRANT 0			0	C	0	8, 469		192.06
192.10 19214 BREAST PUMPS 0 0 0 0			396	C	0	0		192.08
			0	C	0	0		192. 09 192. 10
			0	C	0	0		192.10
192.14 19210 MGH PHYS PRACT MGMT 1, 585 0 0 0 0	192.14	19210 MGH PHYS PRACT MGMT	1, 585	C	0	0	0	192. 14
			0	C	0	6, 352		192. 15 192. 16
			0	C	0	5, 646		192.16
192. 18 19218 MGH FAI RM MED ASSOC 0 0 0 0	192.18	19218 MGH FAIRM MED ASSOC	0	C	0	0	0	192. 18
			0	C	0	2, 823		192. 19 193. 00
			0	C.		0 1. 412		193.00
193.02 19302 MGH FMC GAS CITY 0 0 0 2,823 01	193.021	19302 MGH FMC GAS CITY	o o	C	0		0	193. 02
			0	C	0	-		193.03
			0	C.				193. 04 193. 05
			0	C	0			193.06

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2552-1	0
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/26/2018 2:38 pm	_
Cost Center Description	HOUSEKEEPING		NURSI NG ADMI NI STRATI C	SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	0 193. 0	
193.08 19308 MGH FMC CONVERSE	0	0		0 1, 412	0 193. 0	8
193.09 19309 MGH UPLAND HEALTH	0	0		0 8, 469	0 193. 0	9
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0	0 193. 1	0
193. 11 19311 MGH MGH PSYCHLATRY	0	0		0 0	0 193. 1	1
193. 12 19312 OB/GYN	0	0		0 15, 527	0 193. 1	2
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0 193. 1	5
194.0007963 HEART FAILURE CLINIC	0	0		0 0	0 194. 0	0
194.0107950 MOW	0	35, 243		0 0	0 194. 0	1
194.0207951 MENTAL HEALTH	0	37, 829		0 0	0 194. 0	2
194. 03 07952 ADVERTI SI NG	0	0		0 0	0 194. 0	3
194.0407953 MGH WORK SOLUTIONS	0	0		0 5, 646	0 194. 0	4
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0	0 194. 0	5
194.0807957 MGH SMMP BLDG	0	0		0 0	0 194. 0	8
194.0907958 MGH AMBUCARE BLDG	0	0		0 0	0 194. 0	9
194.1007959 MGH 106 LYONS BLDG	0	0		0 0	0 194. 1	0
194. 11 07960 FAI RMOUNT	0	0		0 0	0 194. 1	1
194. 12 07961 GAS CI TY	0	0		0 0	0 194. 1	2
194. 13 07962 LYONS	0	0		0 0	0 194. 1	3
194. 14 07964 WABASH	0	0		0 0	0 194. 1	4
194. 15 07965 TOBACCO GRANT	0	0		0 0	0 194. 1	5
200.00 Cross Foot Adjustments					200. 0	0
201.00 Negative Cost Centers	0	0		0 0	0 201. 0	
202.00 TOTAL (sum lines 118 through 201)	215, 422	365, 311	71, 02	141, 152	270, 970 202. 0	0

	Financial Systems TION OF CAPITAL RELATED COSTS	MARION GENER	Provi der CO		In Lieu of Form CM Period: Worksheet E	
					From 07/01/2017 Part II Fo 06/30/2018 Date/Time F	Prepared
	Cost Center Description	Subtotal	Intern &	Total	11/26/2018	2:38 pm
			Residents Cost & Post			
			Stepdown			
			Adjustments		_	
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
. 00	00500 ADMI NI STRATI VE & GENERAL					5.0
. 00 . 01	00600 MAI NTENANCE & REPAI RS 00601 CAFETERI A					6.0
. 02	00602 CAFETERIA					6.0
. 00	00700 OPERATION OF PLANT					7.0
. 00	00800 LAUNDRY & LINEN SERVICE					8.0
. 00 0. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. C
3.00	01300 NURSI NG ADMI NI STRATI ON					13. 0
4.00	01400 CENTRAL SERVICES & SUPPLY					14.0
5.00	01500 PHARMACY					15.0
0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 877, 195	0	2, 877, 195	5	30. 0
1.00	03100 I NTENSI VE CARE UNI T	679, 555		679, 555		31.0
	04000 SUBPROVIDER - IPF	0	0	(0	40.0
1.00	04100 SUBPROVIDER - IRF	602, 601	0	602, 60		41.0
2.00 3.00	04200 SUBPROVI DER 04300 NURSERY	0 37,667	0	(37, 667		42. C
5.00	ANCI LLARY SERVICE COST CENTERS	57,007	0	57,001		45.0
0. 00	05000 OPERATI NG ROOM	2, 122, 129	0	2, 122, 129	9	50.0
1.00	05100 RECOVERY ROOM	0	0	(51.0
4.00 7.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	1, 245, 127 111, 296	0	1, 245, 12 111, 296		54.0
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 334		107, 334		58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	324, 149		324, 149		59.0
0.00	06000 LABORATORY	891, 335		891, 335		60.0
0. 01 0. 02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	42, 793	0	42, 793	3	60. 0 60. 0
5.00	06500 RESPIRATORY THERAPY	315, 675	0	315, 675	5	65.0
6.00	06600 PHYSI CAL THERAPY	109, 336		109, 336		66.0
	06900 ELECTROCARDI OLOGY	465, 740		465, 740		69.0
	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	81, 245 0	0	81, 245		69. (71. (
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	410, 726	0	410, 726	6	73.0
0 00	OUTPATIENT SERVICE COST CENTERS	1/0 007		1/0.00	7	
0.00	09000 CLINIC 09100 EMERGENCY	169, 897 849, 871	0	169, 897 849, 871		90. (91. (
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	017,071	0	017,07	•	92.0
2. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(D	92. 0
E 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	275,003	0	275, 003	2	95. 0
5.00	SPECIAL PURPOSE COST CENTERS	275,005	0	275,000	2	95.0
13.00	11300 INTEREST EXPENSE					113. 0
18.00		11, 718, 674	0	11, 718, 674	4	118.0
00 00	NONREIMBURSABLE COST CENTERS	72, 135	0	72, 135	3	190. 0
	19000 PHYSI CLANS' PRI VATE OFFICES	72, 133		72, 13		190.0
92.02	19202 VISITOR MEALS	8, 330	0	8, 330	0	192.0
	19203 GREAT BEGI NNI NGS/MATERNAL	3, 762	0	3, 762		192. 0
	19204 LIFELINE 19205 OWNED PROPERTIES	0 2, 183	0	(2, 183		192. 0 192. 0
	19206 UROLOGY	40, 254		40, 254		192.0
	19211 PARI SH NURSI NG	2,036		2, 036		192. (
	19212 BI OTERRORI SM GRANT	1, 216	0	1, 216		192. (
	19214 BREAST PUMPS 19209 LUNG CENTER	0 13, 769	0	(13, 769		192. ⁻ 192. ⁻
	19209 LONG CENTER 19210 MGH PHYS PRACT MGMT	48, 294		48, 294		192.
92.15	19215 MGH MARION SURGEONS	57, 594	0	57, 594	4	192. ⁻
	19216 MGH MGH MED ONC	23, 700		23, 700		192.
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	69, 460 7, 124		69, 460 7, 12		192. ⁻ 192. ⁻
	19218 MGH FAIRM MED ASSUC	7, 124 21, 538		7, 124 21, 538		192.
	19300 NONPALD WORKERS	21, 330	0	21, 000		193. (
93.01	19301 MGH FMC NORTHWOOD	28, 383		28, 383		193. (
	19302 MGH FMC GAS CITY	20, 119		20, 119		193. C 193. C
00 00	19303 MGH HOSPI TALI STS	67, 187	0	67, 187	/1	1102 (

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/26/2018 2:38 pm
Cost Center Description		Intern & esidents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
193.05 19305 MGH FMC SWAYZEE	9,007	0	9,00		193. 05
193.06 19306 MGH PEDIATRIC CTR	26, 382	0	26, 38		193.06
193.07 19307 MGH SPECIALTY PHYS	7, 168	0	7, 16		193. 07
193.08 19308 MGH FMC CONVERSE	8, 810	0	8, 81	0	193. 08
193.09 19309 MGH_UPLAND_HEALTH	43, 560	0	43, 56	0	193. 09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	193. 10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0	193. 11
193. 12 19312 OB/GYN	68, 540	0	68, 54	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	193. 15
194.0007963 HEART FAILURE CLINIC	449	0	44	9	194.00
194. 01 07950 MOW	35, 243	0	35, 24	3	194.01
194.0207951 MENTAL HEALTH	37, 829	0	37, 82	9	194.02
194. 03 07952 ADVERTI SI NG	7, 901	0	7,90)1	194.03
194.04 07953 MGH WORK SOLUTIONS	22, 699	0	22, 69	19	194.04
194. 05 07954 MGH TAYLOR UNIVERSITY	2, 736	0	2, 73	6	194.05
194.0807957 MGH SMMP BLDG	4,079	0	4,07	'9	194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0	194.09
194.1007959 MGH 106 LYONS BLDG	101	0	10)1	194. 10
194. 11 07960 FAI RMOUNT	406	o	40	06	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	27	0	2	27	194.14
194. 15 07965 TOBACCO GRANT	1,085	0	1, 08		194. 15
200.00 Cross Foot Adjustments	0	0	.,	0	200.00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118 through 201)	12, 552, 381	o	12, 552, 38	1	202.00
	.2,002,001	9	,,		1202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MARION GENERA	L HOSPITAL Provider C		eriod:	worksheet B-1	
					rom 07/01/2017 o 06/30/2018		
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	<u>38 pm</u>
		1.00	4.00	5A	5.00	6.00	
1.00 4.00 5.00 6.00 6.01	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	368, 779 13, 936 60, 400 0 4, 857	44, 325, 765 8, 146, 560 0 0		0	294, 443 4, 857 0	6. 01
13. 00 14. 00	00002 CALETERTA 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	98, 036 2, 113 3, 260 6, 692 696 2, 383 3, 070	575, 208 575, 208 0 0 875, 044 109, 069 2, 549, 837		1, 300, 584 499, 222	98, 036 2, 113 3, 260 6, 692 696 2, 383	7.00 8.00 9.00 10.00 13.00 14.00
30. 00 31. 00 40. 00 41. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 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	43, 198 10, 020 0 9, 585 0	6, 338, 601 1, 895, 619 0 939, 836		11, 329, 856 3, 638, 772 0 2, 263, 372	43, 198	30.00 31.00 40.00 41.00
43.00	04300 NURSERY	0	881, 175	0	1, 324, 058	0	43.00
51.00 54.00 57.00 58.00 59.00 60.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 ONCOLOGY	34, 453 0 20, 686 1, 505 1, 784 5, 040 13, 096 0	0 2, 260, 243 497, 824 241, 631 616, 311 2, 153, 912 943, 033		0 6, 094, 562 1, 241, 853 653, 456 2, 301, 564 9, 188, 303	5, 040	51.00 54.00 57.00 58.00 59.00 60.00
65.00 66.00 69.00 69.01 71.00 72.00	06002 RADIATION ONCOLOGY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 4, 455 881 7, 954 1, 297 0 0 0	0 1, 271, 641 1, 524, 713 781, 669 148, 194 0 0 0 0	0 0 0 0 0 0	0	881 7, 954 1, 297 0 0	65.00 66.00 69.00 69.01 71.00 72.00
91. 00 92. 00	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	2, 832 11, 071 0	280, 047 3, 740, 512 0	0	6, 599, 903		91.00 92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	4, 150	1, 070, 789	0	1, 713, 407	4, 150	95.00
118.00	NONREI MBURSABLE COST CENTERS	367, 450	37, 841, 468	-24, 489, 092	97, 898, 054		
192.00 192.02 192.03 192.04 192.05	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES	1, 329 0 0 0 0 0	31, 683 C 95, 197 C 222, 463	0 0 0 0 0 0 0	0 0 145, 633 0 83, 802	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	19206 UROLOGY 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		322, 463 33, 272 28, 114 0 109, 709 944, 691 490, 811		64, 301 47, 274 0 693, 787 1, 807, 686 2, 543, 896	0 0 0 0 0 0	192.06 192.08 192.09 192.10 192.12 192.14 192.15 192.16
192. 17 192. 18 192. 19 193. 00 193. 01	19217 MGH FMC SOUTH 19218 MGH FAI RM MED ASSOC 19219 MGH FMC MARI ON 19300 NONPAI D WORKERS 19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CI TY		710, 386 94, 677 254, 955 0 312, 388 219, 170		3, 385, 971 367, 664 826, 365 0 1, 424, 491	0 0 0 0 0	192. 17 192. 17 192. 18 192. 19 193. 00 193. 01 193. 02

	ncial Systems	MARION GENERA		01 45 0044		ieu of Form CMS-	
COST ALLOCA	TION - STATISTICAL BASIS		Provider C	CN: 15-0011	Period: From 07/01/20	Worksheet B-1	
					To 06/30/20		
		CAPI TAL	· ·				
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliati		VE MAINTENANCE &	
		FLXT	BENEFITS		& GENERAL	REPAI RS	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1.00	SALARI ES) 4.00	5A	5.00	6.00	
193.0319303	MGH HOSPI TALI STS	0	35, 105		0 4, 027, 9		193.03
193.04 19304	MGH MAR FAM PRACT	0	900, 711		0 3, 286, 3	67 0	193.04
193.05 19305	MGH FMC SWAYZEE	0	73, 188		0 283, 0	32 0	193.05
193.06 19306	MGH PEDIATRIC CTR	0	231, 079		0 1, 232, 5	12 0	193.06
193.07 19307	MGH SPECIALTY PHYS	0	77, 163		0 346, 2		193.07
193.08 19308	MGH FMC CONVERSE	0	101, 422		0 379, 9	32 0	193.08
	MGH UPLAND HEALTH	0	407, 734		0 1, 840, 4		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	503, 419		0 2, 871, 3	0 00	193.12
193. 15 19315	MGH RIVER VIEW BLDG	0	0		0	0 0	193.15
194.0007963	HEART FAILURE CLINIC	0	0		0 27,0	69 0	194.00
194.0107950		0	0		0	0 0	194.01
	MENTAL HEALTH	0	0		0	0 0	194.02
	ADVERTI SI NG	0	169, 111		0 320, 1		194.03
	MGH WORK SOLUTIONS	0	287, 742		0 841, 2		194.04
	MGH TAYLOR UNIVERSITY	0	28, 811		0 146, 4		194.05
	MGH SMMP BLDG	0	0		0 245, 9		194.08
	MGH AMBUCARE BLDG	0	0		0		194.09
	MGH 106 LYONS BLDG	0	0		0 6, 0		194.10
194. 11 07960		0	0		0 24, 4		194.11
194. 12 07961		0	0		0		194.12
194.1307962		0	0		0		194.13
194.14 07964		0	0		0 1,6		194.14
	TOBACCO GRANT	0	21, 296		0 46, 0	37 0	194.15
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	10 550 001	45 05/ 405				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	12, 552, 381	15, 956, 435		24, 489, 0	92 0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	34. 037678	0. 359981		0, 1895	0. 000000	203 00
204.00	Cost to be allocated (per Wkst. B,	34.037070	474, 349		2, 143, 0		204.00
201.00	Part II)		171, 547		2, 143, 0		
205.00	Unit cost multiplier (Wkst. B, Part		0. 010701		0.0165	0. 000000	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
201.00	INAL UNIT COST MULTIPITEL (WKSL. D,	1 1		1	1	1	1201.00

Heal th Financial Systems	MARION GENERA		2N 15 0011		u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 07/01/2017 o 06/30/2018	Worksheet B-1 Date/Time Pre	pared:
Cost Center Description	CAFETERI A (MEALS SERVED)	CAFETERI A (HOURS WORKED)	OPERATI ON OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	11/26/2018 2: HOUSEKEEPI NG (HOURS OF SERVI CE)	
	6. 01	6.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS	1 1		I.			1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 6.01 00601 CAFETERI A 6.02 00602 CAFETERI A	238, 797 228, 283	1, 333, 960				1.00 4.00 5.00 6.00 6.01 6.02
7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 CENTRAL CENTRAL CENTRAL OF A SUPPLY	0 0 0 0 0	32, 563 0 0 20, 035	2, 113 3, 260 6, 692 696	711, 438 0 0 0	56, 524 832 260	10. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	6, 659 67, 661	2, 383 3, 070	7, 673 0	1, 300 728	•
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER	0 0 0 0 0	227, 325 62, 254 0 32, 403 0	10, 020 0 9, 585 0	37, 513 0 19, 784 0	12, 064 3, 328 0 2, 912 0	31.00 40.00 41.00 42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	28, 729	0	0	0	43.00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM	0	181, 469 0	34, 453 0	126, 004 0	7, 696 0	
54.00 05400 RADIOLOGY-DIAGNOSTIC 57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	92, 426 19, 907 4, 831	20, 686 1, 505 1, 784	52, 087 20, 409 0	3, 432 156 0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	22, 478 86, 653	5, 040 13, 096	8, 403 8	1, 040 2, 912	59.00 60.00
60. 01 06001 0NCOLOGY 60. 02 06002 RADI ATI ON ONCOLOGY 65. 00 06500 RESPI RATORY THERAPY	0 0 0	0 0 41, 117	0 0 4, 455	4, 269 0 4, 287	0 0 2, 184	
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	20, 038 33, 163	881 7, 954	14, 280 5, 218 0	0 1, 404	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 656 0 0	1, 297 0 0	0	1, 560 0 0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	9, 361	2, 832	3, 225	1,040	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	138, 337	11, 071	205, 974	12, 480	91.00 92.00
92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92.01
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	50, 891	4, 150	25, 635	364	95.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	228, 283	1, 183, 956	190, 221	708, 787	55, 692	113. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 040 0	1, 329 0	0		190. 00 192. 00
192. 02 19202 VI SI TOR MEALS 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 192. 04 19204 LI FELI NE	10, 514 0	0	0	0	0	192. 02 192. 03 192. 04
192. 05 19205 OWNED PROPERTI ES 192. 06 19206 UROLOGY	0	0 18, 919		0	208 0	192. 05 192. 06
192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS	0	1, 602 968 0		0	0	192. 08 192. 09 192. 10
192.12 192.14 192.14	0	8, 018 48, 795	0	0	0 416	192. 12 192. 14
192.15 19215 MGH MARION SURGEONS 192.16 19216 MGH MGH MED ONC 192.17 19217 MGH FMC SOUTH	000000000000000000000000000000000000000	27, 980 0 0	000000000000000000000000000000000000000	0 0 294	0	192. 15 192. 16 192. 17
192.18 19218 MGH FAIRM MED ASSOC 192.19 19219 MGH FMC MARION	0	0 16, 818	0	80 0	0 0	192. 18 192. 19
193.00 19300 NONPALD WORKERS 193.01 19301 MGH FMC NORTHWOOD 193.02 19302 MGH FMC GAS CLTY	0	0 0	0	0 0 188	0	193. 00 193. 01 193. 02
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT	0	0		0 595	0 0	193. 03 193. 04
193. 05 19305 MGH FMC SWAYZEE	<u> </u>	0	0	0	0	193. 05

Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre	narod
				10 00/ 30/ 2018	11/26/2018 2:	
Cost Center Description	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	(MEALS SERVED)	(HOURS	PLANT	LINEN SERVICE	(HOURS OF	
		WORKED)	(SQUARE	(POUNDS OF	SERVICE)	
			FEET)	LAUNDRY)		
	6.01	6.02	7.00	8.00	9.00	
193.06 19306 MGH PEDIATRIC CTR	0	15, 110		0 23		193.06
193.07 19307 MGH SPECIALTY PHYS	0	4, 307		0 86		193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 67		193.08
193. 09 19309 MGH UPLAND HEALTH	0	0		0 1, 201		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		193.11
193. 12 19312 OB/GYN	0	0		0 0		193.12
193. 15 19315 MGH RIVER VIEW BLDG	0	0		0 0		193. 15 194. 00
194. 00 07963 HEART FAILURE CLINIC 194. 01 07950 MOW	0	0				194.00
194.02 07951 MENTAL_HEALTH	0	0				194.01
194. 02 07951 MENTAL_HEALTH 194. 03 07952 ADVERTI SI NG	0	5, 763		0 0		194.02
194. 04 07953 MGH WORK SOLUTI ONS	0	5,703		0 117		194.03
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0		0 0		194.04
194. 08 07957 MGH SMMP BLDG	0	0				194.03
194. 09 07958 MGH AMBUCARE BLDG	0	0				194.00
194. 10 07959 MGH 106 LYONS BLDG	0	0				194.10
194. 11 07960 FAI RMOUNT	0	0				194.10
194. 12 07961 GAS_CITY	0	0		0 0		194.12
194. 13 07962 LYONS	0	0		0 0		194.13
194. 14 07964 WABASH	0	0		0 0		194.14
194. 15 07965 TOBACCO GRANT	0	684		0 0		194.15
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	1, 712, 529	1, 637, 128	10, 470, 01	3 706, 476	3, 406, 275	1
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 171485	1. 227269	54.65942	6 0. 993025	60. 262455	203.00
204.00 Cost to be allocated (per Wkst. B,	189, 201	180, 871	3, 492, 92	5 118, 694	215, 422	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 792309	0. 135590	18. 23505	6 0. 166837	3. 811160	205.00
)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						007.05
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)				ļ		

Heal th Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENER	AL HOSPITAL Provider CC		Period:	u of Form CMS-2552-10 Worksheet B-1
				From 07/01/2017 To 06/30/2018	Date/Time Prepared:
Cost Center Description	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	11/26/2018 2:38 pm
GENERAL SERVICE COST CENTERS	10.00	13.00	14.00	15.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 6.01 00600 MAINTENANCE & REPAIRS 6.02 00602 CAFETERIA 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01300 NURSI NG ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	90, 243 C C C	857, 172 0	10, 00	0 0 100	1.00 4.00 5.00 6.00 6.01 6.02 7.00 8.00 9.00 10.00 13.00 14.00 15.00
30. 00 03000 ADULTS & PEDIATRICS	54, 082		1, 40		30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	9, 303 C 7, 677 C C	0 32, 403 0	10	0 0	31. 00 40. 00 41. 00 42. 00 43. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 ONCOLOGY 60. 02 066002 RADI ATI ON ONCOLOGY 65. 00 06500 DESEDI ATI ON ONCOLOGY		0 0 0 0 22,478 0 0 0 0 0	30 40 60 5	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50.00 51.00 54.00 57.00 58.00 59.00 60.00 60.01 60.02 65.00
65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 69.01 06900 ELECTROCARDI OLOGY 69.01 06900 ELECTROCARDI OLOGY 69.01 06900 ELECTROCARDI OLOGY 69.01 06901 CARDI AC REHAB 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 00000 ULMA COST CENTERS 000000			25	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 100	65. 00 66. 00 69. 00 69. 01 71. 00 72. 00 73. 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS 000000000000000000000000000000000000	C 1, 13C	138, 337	35	0 0 0 0 0 0	90. 00 91. 00 92. 00 92. 01
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	C	50, 891	10	0 0	95.00
113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	72, 192	853, 221	5, 05	0 100	113. 00 118. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 02 19200 VI SI TOR MEALS 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES 192. 06 19206 UROLOGY 192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS 192. 12 19209 LUNG CENTER 192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARI ON SURGEONS 192. 16 19216 MGH FMC SOUTH 192. 17 19217 MGH FAI RM MED ASSOC 192. 19 19219 MGH FAI RM MED ASSOC 192. 19 19219 MGH FAI RM NOR NORD 193. 00 19300 NONPAI D WORKERS		J J	60 45 40 20	0 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. 06 192. 08 192. 09 192. 10 192. 12 192. 14 192. 14 192. 15 192. 16 192. 17 192. 18 192. 19 193. 00
193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH HOSPITALISTS 193. 04 19304 MGH MAR FAM PRACT			10 20 45	0 0 0 0	193. 01 193. 02 193. 03 193. 04

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2017	Worksheet B-1
				To 06/30/2018	Date/Time Prepared: 11/26/2018 2:38 pm
Cost Center Description	DIETARY	NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	
	,	(DI RECT	(COSTED		
	10.00	NRSING HRS) 13.00	REQUIS.) 14.00	15.00	
193.05 19305 MGH FMC SWAYZEE	0		25		193.05
193. 06 19306 MGH PEDIATRIC CTR	0		10		193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	193.07
193.08 19308 MGH FMC CONVERSE	0	0	10		193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	60		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	193. 11
193. 12 19312 OB/GYN	0	0	1, 10		193. 12
193. 15 19315 MGH RIVER VIEW BLDG 194. 00 07963 HEART FAILURE CLINIC	0	-			193. 15 194. 00
194. 01 07950 MOW	8, 706	-		0 0	194.00
194. 02 07951 MENTAL HEALTH	9,345			0 0	194.02
194. 03 07952 ADVERTI SI NG	0			0 0	194. 03
194.04 07953 MGH WORK SOLUTIONS	0	0	40	0 0	194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0	194. 05
194.08 07957 MGH SMMP BLDG	0	0		0 0	194. 08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0	194. 09
194.1007959 MGH 106 LYONS BLDG	0	0		0 0	194.10
194. 11 07960 FAI RMOUNT	0	0			194. 11
194. 12 07961 GAS_CLTY 194. 13 07962 LYONS	0	0			194. 12 194. 13
194. 14 07964 WABASH	0	0			194.13
194. 15 07965 TOBACCO GRANT	0	0			194.15
200.00 Cross Foot Adjustments	-			-	200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 300, 205	1, 625, 390	818, 22	8 5, 404, 917	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 407821			0 54, 049. 170000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	365, 311	71, 027	141, 15	2 270, 970	204.00
205.00 Unit cost multiplier (Wkst. B, Part	4. 048081	0. 082862	14. 11520	2, 709. 700000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

Heal th Fi	nancial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0011	Peri od:	Worksheet C	
					From 07/01/2017	Part I	
					To 06/30/2018	Date/Time Pre 11/26/2018 2:	pared:
				\0/I		11/26/2018 2:	38 pm
			litie	XVIII	Hospi tal	PPS	
		T , , , , , ,			Costs		
	Cost Center Description		Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	18, 342, 064		18, 342, 0		18, 342, 064	
	100 INTENSIVE CARE UNIT	5, 471, 065		5, 471, 0	65 0	5, 471, 065	31.00
40.00 040	000 SUBPROVIDER - IPF	0			0 0	0	40.00
41.00 04	100 SUBPROVIDER – IRF	3, 631, 404		3, 631, 4	04 0	3, 631, 404	41.00
42.00 042	200 SUBPROVI DER	0			0 0	0	42.00
43.00 043	300 NURSERY	1, 664, 750		1, 664, 7	50 0	1, 664, 750	43.00
ANG	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	19,064,349		19,064,3	49 0	19, 064, 349	50.00
	100 RECOVERY ROOM	0			0 0	0	
	400 RADI OLOGY-DI AGNOSTI C	8, 776, 910		8, 776, 9	-	8, 776, 910	
	700 CT SCAN	1, 613, 590		1, 613, 5		1, 613, 590	1
	800 MAGNETIC RESONANCE I MAGI NG (MRI)	880, 750		880, 7		880, 750	
	900 CARDI AC CATHETERI ZATI ON	3, 187, 233		3, 187, 2			
						3, 187, 233	
	000 LABORATORY	11, 976, 570		11, 976, 5		11, 976, 570	
	001 ONCOLOGY	2, 251, 869		2, 251, 8	69 0	2, 251, 869	
	002 RADI ATI ON ONCOLOGY	0	_		0 0	0	
	500 RESPI RATORY THERAPY	3, 665, 800	0	-11 -		3, 665, 800	
	600 PHYSI CAL THERAPY	3, 008, 546	0	3, 008, 5		3, 008, 546	
	900 ELECTROCARDI OLOGY	2, 412, 863		2, 412, 8		2, 412, 863	69.00
	901 CARDI AC REHAB	518, 225		518, 2	25 0	518, 225	69.01
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 073	300 DRUGS CHARGED TO PATIENTS	15, 427, 531		15, 427, 5	31 0	15, 427, 531	73.00
OU	TPATIENT SERVICE COST CENTERS						
90.00 090	000 CLINIC	1, 133, 121		1, 133, 1	21 0	1, 133, 121	90.00
91.00 09	100 EMERGENCY	9, 889, 587		9, 889, 5	37 O	9, 889, 587	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 214, 884		3, 214, 8		3, 214, 884	1
	201 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0, , 0	
	HER REIMBURSABLE COST CENTERS						1 /2: 01
	500 AMBULANCE SERVICES	2, 479, 528	[2, 479, 5	28 0	2, 479, 528	95.00
	ECIAL PURPOSE COST CENTERS	2, 477, 320		2, 7, 7, 3.	-0	2, 777, 320	/3.00
	300 INTEREST EXPENSE			1			113.00
200.00	Subtotal (see instructions)	118, 610, 639	0	118, 610, 6	39 0	118, 610, 639	
200.00	Less Observation Beds	3, 214, 884		3, 214, 8		3, 214, 884	
202.00	Total (see instructions)	115, 395, 755	0	115, 395, 7	55 0	115, 395, 755	1202. UU

Health Fina	ncial Systems	MARION GENERA	L HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Pre 11/26/2018 2:	epared: 38 pm
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
		(Ratio	
		6.00	7.00	8.00	9.00	10.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS	10 (05 010		10 (05 0	10		30,00
		18, 695, 810		18, 695, 8			30.00
	0 INTENSIVE CARE UNIT 10 SUBPROVIDER - IPF	7, 015, 302 0		7, 015, 30	0		40.00
	0 SUBPROVIDER - IPF	3, 523, 660		3, 523, 6	50		40.00
	O SUBPROVI DER – TRF	3, 523, 660		3, 523, 0	0		41.00
	0 NURSERY	2, 485, 994		2, 485, 9	0		42.00
	LLARY SERVICE COST CENTERS	2,403,774		2,403,7	74		43.00
	O OPERATING ROOM	36, 323, 423	73, 341, 499	109, 664, 93	0. 173842	0.00000	50.00
	O RECOVERY ROOM	00,020,120	0,0,011,17		0 0. 000000		
	0 RADI OLOGY-DI AGNOSTI C	1, 980, 463	30, 128, 593			0. 000000	
	O CT SCAN	4, 258, 757	29, 556, 073				
	O MAGNETIC RESONANCE I MAGING (MRI)	292, 261	3, 172, 444			0.00000	
	O CARDI AC CATHETERI ZATI ON	3, 238, 033	6, 204, 449	9, 442, 48	0. 337542	0. 000000	59.00
60.00 0600	OLABORATORY	3, 870, 489	14, 159, 996	18, 030, 4	0. 664240	0. 000000	60.00
60.01 0600	1 ONCOLOGY	37,074	6, 954, 062	6, 991, 1	0. 322103	0. 000000	60.01
60.02 0600	2 RADIATION ONCOLOGY	0	0		0 0.000000	0. 000000	60.02
65.00 0650	0 RESPI RATORY THERAPY	2, 678, 222	6, 105, 179	8, 783, 40	0. 417355	0. 000000	65.00
66.00 0660	O PHYSI CAL THERAPY	4, 773, 768	5, 402, 379	10, 176, 14	0. 295647	0. 000000	66.00
69.00 0690	0 ELECTROCARDI OLOGY	3, 651, 745	8, 281, 763	11, 933, 50	0. 202192	0. 000000	69.00
69.01 0690	1 CARDI AC REHAB	0	877, 054	877, 0	54 0. 590870	0.00000	69.01
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	71.00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	72.00
	O DRUGS CHARGED TO PATIENTS	8, 858, 170	73, 444, 158	82, 302, 32	28 0. 187450	0.00000	73.00
	ATIENT SERVICE COST CENTERS						
	IO CLINIC	0	1, 022, 120			0.00000	90.00
	O EMERGENCY	11, 083, 508	59, 943, 735			0.00000	
	O OBSERVATION BEDS (NON-DISTINCT PART)	0	6, 397, 506	6, 397, 50		0.00000	
	1 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0.00000	0.00000	92.01
	R REIMBURSABLE COST CENTERS				-		
	O AMBULANCE SERVI CES	0	5, 705, 773	5, 705, 7	0. 434565	0.00000	95.00
	I AL PURPOSE COST CENTERS	, · · · · ·			-		
	O INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	112, 766, 679	330, 696, 783	443, 463, 46	52		200.00
201.00	Less Observation Beds	440 7// /70	000 /0/ 700				201.00
202.00	Total (see instructions)	112, 766, 679	330, 696, 783	443, 463, 46	o∠∣	l	202.00

31.00 03100 INTENSIVE CARE UNIT 31.00 40.00 04000 SUBPROVIDER - IPF 40.00 41.00 04100 SUBPROVIDER - IPF 42.00 42.00 04200 SUBPROVIDER 43.00 43.00 00 43.00 ANCILLARY SERVICE COST CENTERS 43.00 50.00 05000 OPERATING ROOM 0.173842 51.00 05100 RECOVERY ROOM 0.000000 54.00 05400 CT SCAN 0.047718 59.00 05000 CARDIAC CATHETERIZATION 0.37542 59.00 06000 LABORATORY 0.64240 60.01 06000 NESPI RATORY THERAPY 0.41735 61.00 06500 RESPI RATORY THERAPY 0.41735 61.00 06500 RESPI RATORY THERAPY 0.25647 65.00 06900 ELECTROCARDIA CENTERS 66.00 69.00 09000 ELCTROCARDIA CENTERS 72.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 69.00 09000 ELCTROCARDIA CENTERS 72.00 70.00 07000 ICARL ACE REHAB 0.5000000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000	Health Financial Systems	MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
Cost Center Description PPS Inpatient Ratio PPS Inpatient Ratio PPS Inpatient Ratio 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 40.00 04000 SUBPROVIDER - IPF 41.00 41.00 04100 SUBPROVIDER - IRF 42.00 42.00 04200 SUBPROVIDER 41.00 43.00 005000 OPEEATING ROOM 0.173842 50.00 05000 RECOVERY ROOM 0.000000 51.00 05100 RECOVERY ROOM 0.0400 VIRSERY 68.00 05800 INACKETIC RESTAND 51.00 50.00 CT SCAN 0.047718 53.00 DS800 INACKETIC RESONANCE IMAGING (MRI) 0.254206 59.00 CASOL AC CATHETERI ZATION 0.337542 60.00 D6000 LABORATORY 0.64240 60.01 06000 INCOLOGY 0.322103 60.00 06000 PHYSICAL THERAPY 0.27387 60.00 06000 PHYSICAL THERAPY 0.417355 60.00 06000 PHYSICAL THERAPY 0.417355 60.00 CARDIAC REHAB	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 07/01/2017 To 06/30/2018	Part I Date/Time Prepared: 11/26/2018 2:38 pm
Ratio Ratio 10 11.00 11.00 11.00 11.00 11.00 10.00 03100 AUTOR SERVICE COST CENTERS 30.00 11.00 04100 SUBPROVIDER - IPF 40.00 11.00 41.00 41.00 41.00 11.00 04200 SUBPROVIDER - IFF 43.00 11.00 41.00 41.00 42.00 ANCILLARY SERVICE COST CENTERS 43.00 11.00 51.00 50.00 70.00 11.00 05100 RECOVERY ROM 0.0773842 50.00 11.00 05100 RECOVERY ROM 0.047718 54.00 11.00 05100 RECOVERY ROM 0.047718 58.00 11.00 0500 CARDIA CCATHETERIZATION 0.337542 59.00 11.00 0.000000 664240 60.00 60.00 10.00000 LECERCARDIALC RESONANCE IMAGI NG (MRI) 0.222103 60.02 10.0010 NUCOLOGY 0.222103 60.02 60.02 10.0010 NUCOLOGY 0.220192			Title XVIII	Hospi tal	PPS
11.00 11.00 14.01 11.00 15.00 03000 11.00 03000 11.00 03000 11.00 03100 11.00 03100 11.00 03100 11.00 03100 11.00 03100 11.00 03100 11.00 03100 11.00 03100 11.00 03100 11.00 03100 11.00 04100 04100 SUBPROVI DER - 1 PF 11.00 41.00 11.00 04100 04300 SUBPROVI DER - 1 RF 11.00 42.00 43.00 04300 004300 SUBPROVI DER - 1 RF 50.00 05000 005000 REVATIN CROM 0.000000 CFS.00 51.00 S5000 52.00 S5000 53.00 S5000 53.00 S5000 54.00	Cost Center Description				
INPATI ENT NOUTINE SERVICE COST CENTERS 30.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 51.00 50.00 51.00 50.00 51.00 51.00 51.00 54.00 54.00 54.00 54.00 54.00 58.00 58.00 58.00 58.00 58.00					
30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 40.00 SUBPROVIDER - IPF 41.00 41.00 04100 SUBPROVIDER - IRF 41.00 42.00 42.00 42.00 42.00 042000 SUBPROVIDER - IRF 43.00 43.00 043000 NUPSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 REDRATIN G ROM 0.173842 50.00 05000 RADICTIC RESONANCE I MAGING (MRI) 0.273347 51.00 05700 CT SCAN 0.047718 58.00 05800 MAONETIC RESONANCE I MAGING (MRI) 0.337542 60.00 06000 ALBORATORY 0.64240 60.01 60.01 06001 ONCOLOGY 0.322103 60.01 60.00 06000 RESPI RATORY THERAPY 0.417355 65.00 60.00 06000 RESPI RATORY THERAPY 0.292647 66.00 60.00 06000 PHYSI CAL THERAPY 0.292192 69.00 69.00 069001 CARDIA CREHAB 0.590870		11.00			
31 00 03100 INTENSIVE CARE UNIT 31.00 40.00 04000 SUBPROVIDER - IPF 40.00 41.00 04100 SUBPROVIDER - IFF 42.00 42.00 04200 SUBPROVIDER - IFF 42.00 43.00 04300 SUBPROVIDER 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROM 0.173842 51.00 05000 OPERATING ROM 0.000000 54.00 054000 CT SCAN 0.047718 59.00 05000 CARDIA CATHERIZATION 0.37552 59.00 06000 CARDIA CATHERIZATION 0.337542 50.01 06000 NOCLOGY 0.322103 60.01 06000 NESPI RATORY 0.64240 60.01 06000 NESPI RATORY THERAPY 0.417355 61.00 06500 RESPI RATORY THERAPY 0.417355 62.00 065000 PHYSI CAL THERAPY 0.596870 69.00 09000 CARDIA CA RHEAB 0.5090870 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.187450 72.00 07200 DRUCS CHAREAB 0.100					
40.00 04000 SUBPROVI DER - 1 PF 40.00 41.00 04100 SUBPROVI DER - 1 RF 41.00 42.00 04200 SUBPROVI DER 41.00 43.00 04300 NUBSERY 43.00 ANCILLARY SERVI CE COST CENTERS 50.00 50.00 51.00 51.00 OS100 RECOVERY ROM 0.0437347 54.00 51.00 OS400 RADIOLOGY-DI AGNOSTI C 0.273347 54.00 57.00 OS400 RADIOLOGY-DI AGNOSTI C 0.273347 54.00 58.00 OS600 LARGING (MRI) 0.254206 58.00 58.00 59.00 OS900 CARDIAC CATHETERI ZATI ON 0.337542 59.00 60.01 60.01 06001 NOCOLOGY 0.322103 60.01 60.02 60.02 ROGON RESPI RATORY THERAPY 0.417355 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.					30.00
41.00 VID0 SUBPROVI DER - 1 RF 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 SUBPROVI DER 43.00 ANCILLARY SERVICE COST CENTERS 42.00 50.00 05000 OPECATING ROOM 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05100 CT SCAN 0.047718 57.00 57.00 0500 CARDIA CATHERIZATION 0.327542 59.00 59.00 05000 CARDIA CATHERIZATION 0.322103 60.00 60.01 06001 ADBARTORY 0.664240 60.00 60.02 ROGOI RADIATION ONCOLOGY 0.322103 60.01 61.02 06500 RESPI RATORY THERAPY 0.417355 65.00 62.00 06500 RESPI RATORY THERAPY 0.295647 66.00 69.00 06500 RESPI RATORY THERAPY 0.295647 69.00 69.00 07300 RUBIAC RHARED TO PATIENTS 0.00000 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.00000 72.00 73.00 07300 RUBIAC RHARED TO PATIENTS 0.187450 73.00	31.00 03100 INTENSIVE CARE UNIT				31.00
42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 DEPRATING ROOM 50.00 51.00 05100 RCOVERY ROOM 0.000000 51.00 51.00 05100 RCOVERY ROOM 0.00000 51.00 51.00 05700 CT SCAN 0.04300 0.04300 56.00 05800 MAGHLENC ENDANCE IMAGING (MRI) 0.254206 58.00 59.00 05900 CARDI AC CATHETERI ZATION 0.337542 69.00 60.01 06001 MOROLLGGY 0.322103 60.00 60.02 06500 RESPI RATORY 0.417355 65.00 66.00 06500 RESPI RATORY 0.295647 66.00 69.00 06900 LECETRCARDI LOGY 0.295647 66.00 69.00 06900 LEVE CHARGED TO PATI ENTS 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72.00 73.00 090100 CHARGENCY 0.187450 91.00	40. 00 04000 SUBPROVIDER - IPF				40.00
43.00 04300 NURSERY 43.00 ANCLLARY SERVICE COST CENTERS 43.00 50.00 05000 OPENATING ROM 0.173842 51.00 05100 RECOVERY ROM 0.00000 54.00 05400 RADICLORY-DLAGNOSTIC 0.273347 55.00 05500 CT SCAN 0.047718 55.00 58.00 05500 CARDIAC CATHETRIZATION 0.337542 59.00 60.00 06000 LABORATORY 0.64240 60.00 60.01 06001 NCOLOGY 0.332542 59.00 60.02 06002 RADI CLARORATORY 0.64240 60.00 60.01 06001 NCOLOGY 0.322103 60.00 60.02 06002 RADI ATION ONCOLOGY 0.322103 60.00 61.01 06000 INTINERPY 0.255647 65.00 65.00 06500 RESPI RATORY THERAPY 0.202192 69.00 69.00 06900 ILCETROCARDI OLOGY 0.202192 69.00 69.00 06900 ILCARDIAC REHAB 0.590870 71.00 <tr< td=""><td>41.00 04100 SUBPROVIDER - IRF</td><td></td><td></td><td></td><td>41.00</td></tr<>	41.00 04100 SUBPROVIDER - IRF				41.00
ANCLILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.173842 50.00 51.00 05100 RCOVENY ROOM 0.00000 51.00 51.00 05100 RCOVENY ROOM 0.00000 51.00 51.00 05100 RCOVENY ROOM 0.047718 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.254206 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.337542 60.00 60.00 Io6001 INCOLOGY 0.322103 60.01 60.01 O6000 LABRATORY 0.040000 66.00 65.00 06500 RESPIRATORY THERAPY 0.417355 66.00 66.00 06600 PHYSI CAL THERAPY 0.295647 66.00 69.01 06901 CLARUA CEHARB 0.590870 71.00 71.00 07300 IPAL ECTROCARDE TO PATIENTS 0.187450 72.00 07300 IPAL ECTROCARDE 0.90000 73.00 07300 IPAL ECTROCARDE 0.139237 <td>42. 00 04200 SUBPROVI DER</td> <td></td> <td></td> <td></td> <td>42.00</td>	42. 00 04200 SUBPROVI DER				42.00
50.00 OSOOO OPERATI NG ROOM 0.173842 50.00 51.00 OS100 RECOVERY ROOM 0.000000 51.00 54.00 OS400 RADI LOCY-DI AGNOSTI C 0.273347 51.00 57.00 OS700 CT SCAN 0.047718 57.00 58.00 OS800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.254206 58.00 59.00 OS900 CARDI AC CATHETERI ZATI ON 0.337542 59.00 60.01 OKOOLOGY 0.322103 60.01 60.01 OKOOLOGY 0.322103 60.02 60.02 O6600 RESPI RATIORY HERAPY 0.295647 66.00 60.01 OKOOLOGY 0.202192 69.00 69.01 ORSHO CRESPI RATIORY THERAPY 0.295647 66.00 69.00 CARDI CAR CHAB 0.590870 71.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 O7200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 72.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.502521 90.	43. 00 04300 NURSERY				43.00
50.00 OSOOO OPERATI NG ROOM 0.173842 50.00 51.00 OS100 RECOVERY ROOM 0.000000 51.00 54.00 OS400 RADI LOCY-DI AGNOSTI C 0.273347 51.00 57.00 OS700 CT SCAN 0.047718 57.00 58.00 OS800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.254206 58.00 59.00 OS900 CARDI AC CATHETERI ZATI ON 0.337542 59.00 60.01 OKOOLOGY 0.322103 60.01 60.01 OKOOLOGY 0.322103 60.02 60.02 O6600 RESPI RATIORY HERAPY 0.295647 66.00 60.01 OKOOLOGY 0.202192 69.00 69.01 ORSHO CRESPI RATIORY THERAPY 0.295647 66.00 69.00 CARDI CAR CHAB 0.590870 71.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 O7200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 72.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.502521 90.					
51.00 05100 RECOVERY ROOM 0.000000 51.00 51.00 05400 RADI (LOGY-DI AGNOSTI C 0.273347 57.00 57.00 05700 CT SCAN 0.047718 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.254206 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.337542 59.00 60.00 06000 LABORATORY 0.664240 60.01 60.01 06001 ONCOLOGY 0.300000 60.01 60.02 06000 RESPI RATORY THERAPY 0.417335 65.00 61.00 06600 PHYSI CAL THERAPY 0.292647 66.00 62.00 06900 ELECTRCCARDI OLOGY 0.202192 69.01 63.00 06900 ILCARNI AC REHAB 0.590870 69.00 64.00 06900 ELECTRCCARDI OLOGY 0.202192 69.01 69.01 06900 ILCARNI AC REHAB 0.590870 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.0000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.187450 73.00 72.00 07200 IMPL UPL HARGED TO PATI ENTS 0		0, 173842			50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.273347 54.00 57.00 05700 CT SCAN 0.047718 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0.337542 59.00 60.00 06000 LABORATORY 0.64240 60.01 60.01 0K000 OKOOL ORCUGOSY 0.322103 60.01 60.02 06000 RADI ATI ON ONCOLOGY 0.32213 60.01 60.00 06000 RSPI RATORY 0.47355 65.00 60.00 06000 RESPI RATORY THERAPY 0.295647 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 69.01 69.01 06000 PHSI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 71.00 07100 MPL AL SUPPLIES CHARGED TO PATI ENTS 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 09100 ELERGENCY 0.139237 90.00 90.00 09100 ELERGENCY 0.139237 91.00 91.00 09200 D					51.00
57.00 05700 CT SCAN 0.047718 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.254206 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.337542 59.00 60.00 06000 LABORATORY 0.664240 60.00 60.01 00C02 RADI ATI ON ONCOLOGY 0.322103 60.00 60.02 6000 RADI ATI ON ONCOLOGY 0.222103 60.00 65.00 06500 RESPI RATORY THERAPY 0.417355 65.00 66.00 06400 PHYSI CAL THERAPY 0.2925647 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 69.00 69.01 06901 CARDI AC REHAB 0.590870 71.00 71.00 07100 MEDI AL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0.187450 73.00 0.00 07300 DRUES CHARGED TO PATI ENTS 0.187450 73.00 73.00 07300 DRUES CHARGED TO PATI ENTS 0.139237 90.00 92.01 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0.5002521 92.01 92.01 09200 DESERVATI ON BEDS (NON-DI STI NCT PART)					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.254206 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.337542 59.00 60.00 LABORATORY 0.664240 60.01 60.01 NOCOLOGY 0.322103 60.01 60.02 CARDIA TI ON ONCOLOGY 0.000000 60.01 60.02 CARDIA TI ON ONCOLOGY 0.000000 60.02 65.00 OESON RATORY THERAPY 0.417355 65.00 66.00 06400 LECTROCARDI OLOGY 0.295647 66.00 69.00 04900 LECTROCARDI OLOGY 0.202192 69.00 69.01 OA901 CARDIA C REHAB 0.590870 69.01 71.00 OT100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 INPLI DEV. CHARGED TO PATIENTS 0.187450 72.00 73.00 ORUGS CHARGED TO PATIENTS 0.187450 72.00 72.00 72.00 O2000 DESERVATION BEDS (NON-DISTINCT PART) 0.502521 90.00 90.00 OP200 DESERVATION BEDS (DISTINCT PART) 0.000000 <td></td> <td></td> <td></td> <td></td> <td></td>					
59.00 05900 CARDI AC CATHETERI ZATI ON 0.337542 59.00 60.00 06000 LABORATORY 0.664240 60.01 60.01 06001 OKCOLOGY 0.322103 60.00 60.02 RADI ATI ON ONCOLOGY 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0.417355 65.00 66.00 06600 PHYSI CAL THERAPY 0.295647 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 69.00 69.01 06901 CARDI AC REHAB 0.590870 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.107450 73.00 00 07300 DRUGS CHARGED TO PATI ENTS 0.137450 73.00 00 07000 LENC COST CENTERS 90.00 90.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0.502521 92.00 92.01 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92.00 92.01					
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60.01 06001 0NC0L0GY 0.322103 60.01 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0.417355 65.00 66.00 06600 PHYSI CAL THERAPY 0.295647 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 69.00 69.01 06901 CARDI AC REHAB 0.590870 69.01 71.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.187450 73.00 0.01 09000 CLI NI C 1.108599 90.00 90.00 OPGOOL DISTI NCT PART) 0.502521 92.01 92.01 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92.01 92.01 OPGOOL DISTI NCT PART) 0.032521 92.01 92.01 DSERVATI ON BEDS (DI STI NCT PART) 0.0000000 92.01 92.01					
60.02 06002 RADI ATI ON ONCOLOGY 0.000000 60.02 65.00 06500 RESPI RATORY THERAPY 0.417355 65.00 66.00 06600 PHYSI CAL THERAPY 0.295647 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 69.01 69.01 0ARDI AC REHAB 0.590870 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 D7300 REGENCY 0.187450 72.00 90.00 09000 CLINIC 1.108599 90.00 91.00 09200 OBERVATI ON BEDS (NON-DI STINCT PART) 0.502521 92.00 92.01 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 92.01 92.01 95.00 OPSOO AMBULANCE SERVICES 0.434565 95.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 20.00 900.00 Less Observati on Beds 201.00 201.00 201.00 201.00					
65.00 06500 RESPIRATORY THERAPY 0.417355 65.00 66.00 06600 PHYSI CAL THERAPY 0.295647 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 69.00 69.01 06901 CARDI AC REHAB 0.590870 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 MPL. DEV. CHARGED TO PATI ENTS 0.187450 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.187450 70.00 0017PATI ENT SERVI CE COST CENTERS 0.139237 90.00 90.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.502521 92.01 92.01 09201 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92.01 92.01 09201 OBSERVATI ON BEDS (INSTI NCT PART) 0.000000 92.01 95.00 09500 AMBULANCE SERVI CES 0.434565 95.00 95.00 09500 AMBULANCE SERVI CES 0.434565 95.00 920.01 011300 INTEREST EXPENSE 113.00 113.00 1013.00 I 1300 INTEREST EXPENSE 200.					
66.00 06600 PHYSI CAL THERAPY 0.295647 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 69.00 69.01 06900 CARDI AC REHAB 0.590870 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.187450 73.00 017001 MERGENCY 0.139237 90.00 90.00 09200 OBSERVATION BEDS (NON-DI STI NCT PART) 0.502521 92.00 92.01 092001 OBSERVATION BEDS (DI STI NCT PART) 0.000000 92.00 95.00 09500 AMBULANCE SERVI CES 0.434565 95.00 95.01 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 200.00 201.00 201.00					
69.00 06900 ELECTROCARDIOLOGY 0.202192 69.00 69.01 06901 CARDIA C REHAB 0.590870 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 073.00 07300 RUGS CHARGED TO PATIENTS 0.187450 73.00 001TPATIENT SERVICE COST CENTERS 0.139237 90.00 90.00 90.00 09000 CLINIC 1.108599 91.00 91.00 09201 0BSERVATION BEDS (NON-DISTINCT PART) 0.502521 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 92.01 01HER REIMBURSABLE COST CENTERS 0.434565 92.01 92.01 09201 INBULANCE SERVICES 0.434565 95.02 92.01.1300 INTREST EXPENSE 113.00 113.00 113.00 113.00 INTREST EXPENSE 200.00 201.00 201.00 201.00 Less Observation Beds 201.00 201.00 201.00					
69. 01 06901 CARDI AC REHAB 0. 590870 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 73. 00 07000 DRUGS CHARGED TO PATIENTS 0. 187450 73. 00 00.00 09000 CLINIC 1. 108599 90. 00 90. 00 09000 EMERGENCY 0. 139237 91. 00 92. 01 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 502521 92. 01 92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0. 000000 92. 01 92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0. 000000 92. 01 92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0. 000000 92. 01 92. 01 07500 AMBULANCE SERVICES 0. 434565 95. 00 95. 01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00					
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 73.00 001704TIENT SERVICE COST CENTERS 0.187450 73.00 90.00 09000 CLINIC 1.108599 90.00 91.00 09100 BMERGENCY 0.139237 91.00 92.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.502521 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92.01 07100ER REI MBURSABLE COST CENTERS 0.434565 95.00 95.00 09500 AMBULANCE SERVICES 0.434565 95.00 9113.00 11300 INTEREST EXPENSE 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00 201.00					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 73.00 001PATIENT SERVICE COST CENTERS 0.187450 73.00 73.00 90.00 09000 CLINIC 1.108599 90.00 91.00 09100 EMERGENCY 0.139237 91.00 92.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.502521 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92.01 07HER REIMBURSABLE COST CENTERS 0.434565 95.00 95.00 09500 AMBULANCE SERVICES 0.434565 95.00 95.01 113.00 INTERST EXPENSE 113.00 11300 INTERST EXPENSE 113.00 200.00 Less Observation Beds Subtotal (see instructions) 200.00 201.00 201.00					
73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 73.00 0UTPATIENT SERVICE COST CENTERS 0.187450 90.00 90.00 90.00 09000 CLINIC 1.108599 90.00 91.00 09100 EMERGENCY 0.139237 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.502521 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 92.01 0THER REIMBURSABLE COST CENTERS 0.434565 95.00 95.00 95.00 09500 AMBULANCE SERVICES 0.434565 95.00 97.00 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) Less Observation Beds 200.00 201.00					
OUTPATI ENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 1.108599 90.00 91.00 09100 EMERGENCY 0.139237 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0.502521 92.00 92.01 09201 DBSERVATI ON BEDS (DI STINCT PART) 0.000000 92.01 0THER REI MBURSABLE COST CENTERS 0.434565 95.00 9500 SPECIAL PURPOSE COST CENTERS 113.00 1NTEREST EXPENSE 113.00 113.00 1NTEREST EXPENSE 200.00 201.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 201.00 201.00					
90. 00 09000 CLINIC 1.108599 90. 00 91. 00 09100 EMERGENCY 0.139237 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.502521 92. 00 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 92. 01 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0.434565 95. 00 09500 AMBULANCE COST CENTERS 95. 00 9113.00 INTEREST EXPENSE 113.00 11300 200. 00 Subtotal (see instructions) 200.00 201.00 201. 00 Less Observation Beds 201.00 201.00		0. 187450			73.00
91.00 09100 EMERGENCY 0.139237 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.502521 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0.00000 92.01 07 07500 AMBULANCE SERVICES 0.434565 92.01 95.00 09500 AMBULANCE SERVICES 0.434565 95.00 91.13.00 11300 INTEREST EXPENSE 113.00 200.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00					
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.502521 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 92.01 0THER REIMBURSABLE COST CENTERS 0.434565 92.01 95.00 OPSOCI AMBULANCE SERVICES 0.434565 95.00 91.100 INTEREST EXPENSE 113.00 11300 11300 11300 11300 11300 200.00 201.00 20	90. 00 09000 CLINIC	1. 108599			90.00
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 92.01 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.434565 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 201.00 Less Observation Beds 201.00 201.00	91.00 09100 EMERGENCY	0. 139237			91.00
OTHER REIMBURSABLE COST CENTERS 07500 AMBULANCE SERVICES 0.434565 95.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 11300 100	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 502521			92.00
OTHER REIMBURSABLE COST CENTERS 07500 AMBULANCE SERVICES 0.434565 95.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 11300 100	92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92.01
95. 00 09500 AMBULANCE SERVICES 0. 434565 95. 00 SPECIAL PURPOSE COST CENTERS 113.00 1NTEREST EXPENSE 113.00 11300 100 <					
SPECIAL PURPOSE COST CENTERS113.0011300INTEREST EXPENSE113.00200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00	95. 00 09500 AMBULANCE SERVICES	0. 434565			95.00
113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	SPECIAL PURPOSE COST CENTERS				
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00					113.00
201.00 Less Observation Beds 201.00					200.00
					201.00
	202.00 Total (see instructions)				202.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0011	Period:	Worksheet C	
				From 07/01/2017	Part I	
				To 06/30/2018	Date/Time Pre 11/26/2018 2:	pared:
					11/26/2018 2:	38 pm
		11 TI	e XIX	Hospi tal	Cost	
	T		T 0	Costs		
Cost Center Description		Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)	0.00		4.00		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	18, 342, 064		18, 342, 0		18, 342, 064	
31.00 03100 INTENSIVE CARE UNIT	5, 471, 065		5, 471, 0	65 0	5, 471, 065	
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	
41. 00 04100 SUBPROVIDER – IRF	3, 631, 404		3, 631, 40	0 0	3, 631, 404	41.00
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
43. 00 04300 NURSERY	1, 664, 750		1, 664, 7	50 0	1, 664, 750	43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	19, 064, 349		19, 064, 34	49 0	19, 064, 349	50.00
51.00 05100 RECOVERY ROOM	0			0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 776, 910		8, 776, 9 [.]	10 0	8, 776, 910	54.00
57.00 05700 CT SCAN	1, 613, 590		1, 613, 59		1, 613, 590	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	880, 750		880, 7		880, 750	
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 187, 233		3, 187, 2		3, 187, 233	
60. 00 06000 LABORATORY	11, 976, 570		11, 976, 5		11, 976, 570	
60. 01 06001 0NC0L0GY	2, 251, 869		2, 251, 8		2, 251, 869	
60. 02 06002 RADIATION ONCOLOGY	2,201,007		2/201/0	0 0	0	1
65. 00 06500 RESPI RATORY THERAPY	3, 665, 800	0	3, 665, 80	0 0	3, 665, 800	
66. 00 06600 PHYSI CAL THERAPY	3,008,546	0	3, 008, 5		3, 008, 546	
69. 00 06900 ELECTROCARDI OLOGY	2, 412, 863	0	2, 412, 8		2, 412, 863	
69. 01 06901 CARDI AC REHAB	518, 225		518, 2		518, 225	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			516, 2.			1
	0			0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15 407 501		15 407 5	0 0	15 407 501	
73.00 O7300 DRUGS CHARGED TO PATIENTS	15, 427, 531		15, 427, 5	31 0	15, 427, 531	73.00
OUTPATIENT SERVICE COST CENTERS	1 1 1 1 1 1 1 1		1 100 1	ada		
90. 00 09000 CLINIC	1, 133, 121		1, 133, 12		1, 133, 121	
91.00 09100 EMERGENCY	9, 889, 587		9, 889, 5		9, 889, 587	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 214, 884		3, 214, 8		3, 214, 884	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0	92.01
OTHER REI MBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 479, 528		2, 479, 5	28 0	2, 479, 528	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	118, 610, 639	0			118, 610, 639	
201.00 Less Observation Beds	3, 214, 884		3, 214, 8	84	3, 214, 884	
202.00 Total (see instructions)	115, 395, 755	0	115, 395, 7	55 O	115, 395, 755	1202 00

Heal th Fi	nancial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Pre 11/26/2018 2:	epared: 38 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	18, 695, 810		18, 695, 8			30.00
	100 INTENSIVE CARE UNIT	7,015,302		7, 015, 30	02		31.00
	000 SUBPROVIDER - IPF	0			0		40.00
	100 SUBPROVIDER - IRF	3, 523, 660		3, 523, 6	50		41.00
	200 SUBPROVI DER	0			0		42.00
	300 NURSERY	2, 485, 994		2, 485, 9	94		43.00
	CILLARY SERVICE COST CENTERS				-		
	000 OPERATING ROOM	36, 323, 423	73, 341, 499	109, 664, 9		0. 000000	
	100 RECOVERY ROOM	0	0		0 0. 000000	0. 000000	
	400 RADI OLOGY-DI AGNOSTI C	1, 980, 463	30, 128, 593			0.00000	54.00
	700 CT SCAN	4, 258, 757	29, 556, 073	33, 814, 8		0.00000	
58.00 058	800 MAGNETIC RESONANCE IMAGING (MRI)	292, 261	3, 172, 444	3, 464, 70	0. 254206	0.00000	58.00
59.00 059	900 CARDI AC CATHETERI ZATI ON	3, 238, 033	6, 204, 449	9, 442, 4	0. 337542	0.00000	59.00
60.00 060	000 LABORATORY	3, 870, 489	14, 159, 996	18, 030, 4	0. 664240	0.00000	60.00
60.01 060	001 ONCOLOGY	37,074	6, 954, 062	6, 991, 1	36 0. 322103	0.00000	60.01
60.02 060	002 RADIATION ONCOLOGY	0	0		0 0.000000	0.00000	60.02
65.00 06	500 RESPI RATORY THERAPY	2, 678, 222	6, 105, 179	8, 783, 40	0. 417355	0.00000	65.00
66.00 06	600 PHYSI CAL THERAPY	4, 773, 768	5, 402, 379	10, 176, 14	0. 295647	0. 000000	66.00
69.00 06	900 ELECTROCARDI OLOGY	3, 651, 745	8, 281, 763	11, 933, 50	0. 202192	0.00000	69.00
69.01 069	901 CARDI AC REHAB	0	877, 054		0. 590870	0. 000000	69.01
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	72.00
73.00 073	300 DRUGS CHARGED TO PATIENTS	8, 858, 170	73, 444, 158	82, 302, 3	0. 187450	0. 000000	73.00
	TPATIENT SERVICE COST CENTERS					-	1
90.00 090	000 CLINIC	0	1, 022, 120	1, 022, 12	1. 108599	0.00000	90.00
91.00 09	100 EMERGENCY	11, 083, 508	59, 943, 735	71, 027, 24	0. 139237	0.00000	91.00
92.00 093	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	6, 397, 506	6, 397, 50	0. 502521	0. 000000	92.00
92.01 093	201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0.000000	0.00000	92.01
	HER REIMBURSABLE COST CENTERS	Г					
	500 AMBULANCE SERVICES	0	5, 705, 773	5, 705, 7	0. 434565	0.00000	95.00
	ECIAL PURPOSE COST CENTERS		-, ,	2, 20, 1			1
	300 I NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	112, 766, 679	330, 696, 783	443, 463, 46	52		200.00
201.00	Less Observation Beds		200, 070, 100				201.00
202.00	Total (see instructions)	112, 766, 679	330, 696, 783	443, 463, 4	52		202.00
202.00		1 12, 700, 077	300, 070, 700	1 110, 100, 40		I	1-02.00

Health Financial Systems	MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prep 11/26/2018 2:3	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVI DER - I PF					40.00
41.00 04100 SUBPROVIDER - IRF					41.00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·				
50. 00 05000 OPERATI NG 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 ONCOLOGY	0. 000000				60. 01
60. 02 06002 RADIATION ONCOLOGY	0. 000000				60.02
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 06901 CARDI AC REHAB	0. 000000				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0.000000				95.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
	1				
201.00 Less Observation Beds				Ľ	201.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2017 To 06/30/2018		pared: 38 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	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, 877, 195	0	2, 877, 19		169. 23	30.00
31.00 INTENSIVE CARE UNIT	679, 555		679, 55	5 3, 638	186. 79	31.00
40.00 SUBPROVIDER - IPF	0	0)	0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	602, 601	0	602,60	1 2, 681	224.77	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43.00 NURSERY	37,667		37,66	7 2, 031	18.55	43.00
200.00 Total (lines 30 through 199)	4, 197, 018		4, 197, 01	8 25, 352		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	7,057	1, 194, 256	,			30.00
31.00 INTENSIVE CARE UNIT	1, 152	215, 182				31.00
40.00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	2,053	461, 453				41.00
42. 00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	10, 262	1, 870, 891				200.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Pre 11/26/2018 2:	
		Title	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	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 122, 129	109, 664, 922	0. 01935	51 12, 481, 967	241, 539	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, 245, 127	32, 109, 056	0. 03877	78 1, 028, 087	39, 867	54.00
57.00 05700 CT SCAN	111, 296	33, 814, 830	0.00329	2, 523, 608	8, 305	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	107, 334	3, 464, 705	0. 03097	140, 701	4, 359	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	324, 149	9, 442, 482	0. 03432	1, 413, 655	48, 529	59.00
60. 00 06000 LABORATORY	891, 335	18, 030, 485	0. 04943	1, 984, 350	98, 096	60.00
60. 01 06001 ONCOLOGY	42, 793	6, 991, 136	0. 00612	21 23, 576	144	60.01
60. 02 06002 RADIATION ONCOLOGY	0		0.00000	0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	315, 675	8, 783, 401	0. 03594	1, 357, 610	48, 793	65.00
66. 00 06600 PHYSI CAL THERAPY	109, 336	10, 176, 147	0. 01074	1, 122, 494	12,060	66.00
69.00 06900 ELECTROCARDI OLOGY	465, 740	11, 933, 508	0. 03902	1, 962, 356	76, 587	69.00
69. 01 06901 CARDI AC REHAB	81, 245	877,054	0. 09263	34 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0, 00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0, 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	410, 726	82, 302, 328	0.00499	4, 117, 863	20, 548	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	169, 897	1, 022, 120	0. 16622	20 0	0	90.00
91.00 09100 EMERGENCY	849, 871				62, 881	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	504, 296				0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0				0	92.01
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	7, 750, 949	406, 036, 923		33, 411, 716	661, 708	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0011	Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lie	eu of Form CMS-	2552-10
Cost Center Description Nursing School Nursing School Nursing School Partie Nation Partie Part Part Part Part Part Part Part Part	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			From 07/01/2017 To 06/30/2018	Part III Date/Time Pre	epared: 38 pm
Post-Stepdown Adjustments Post-Stepdown Adjustments Cost Education Cost 20.00 Medical Education Cost 20.00 Medical 20.00 Medical Education Cost 20.00 Medical 20.00 Medical 20						PPS	
Adjustments Adjustments Education Cost 1A 1.00 2A 2.00 3.00 0.00 03000 ADULTS & PEDIATRICS 0	Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
INPATIENT ROUTINE SERVICE COST CENTERS 0		Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
INPATI ENT ROUTINE SERVICE COST CENTERS 0		Adjustments		Adjustments		Education Cost	
30. 00 03000 ADULTS & PEDIATRICS 0		1A	1.00	2A	2.00	3.00	
31.00 00 0010 INTENSIVE CARE UNIT 0	INPATIENT ROUTINE SERVICE COST CENTERS				· ·		
40.00 04000 SUBPROVI DER - IPF 0 </td <td>30. 00 03000 ADULTS & PEDI ATRI CS</td> <td>0</td> <td>0</td> <td>I</td> <td>0 0</td> <td>0</td> <td>30.00</td>	30. 00 03000 ADULTS & PEDI ATRI CS	0	0	I	0 0	0	30.00
40.00 04000 SUBPROVI DER - IPF 0 </td <td>31. 00 03100 I NTENSI VE CARE UNI T</td> <td>0</td> <td>0</td> <td></td> <td>o o</td> <td>0</td> <td>31.00</td>	31. 00 03100 I NTENSI VE CARE UNI T	0	0		o o	0	31.00
41.00 04100 SUBPROVI DER - IRF 0		0	0		0 0	0	40.00
42.00 04200 SUBPROVI DER 0		0	0		0 0	0	41.00
43.00 04300 NURSERY 0		0	0		0 0		
200.00 Total (lines 30 through 199) 0		0	0		0 0	-	
Cost Center Description Swing-Bed Adjustment (see instructions) Total Costs (sum of cols. instructions) Total Patient Days Per Diem (col. 5 ÷ col. 6) Inpatient Program Days 30.00 00000 ADULTS & PEDIATRICS 030000 ADULTS & PEDIATRICS 0 0 7.00 8.00 31.00 03000 INTENSI VE CARE UNIT 0 0 3.638 0.00 1,152 30.00 41.00 SUBPROVIDER - IPF 0 0 0 2,681 0.00 0 42.00 42.00 SUBPROVIDER - IRF 0 0 0 0 2,031 0.00 0 42.00 43.00 04300 NURSERY 0 0 2,031 0.00 0 42.00 25,352 10,262 200.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 Gast Center Description Inpatient Program Pass-Through Pass-Through Cost Center Description 10,262 200.00 10,262 200.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03100 NOULTS & PEDIATRICS 0 30.00 31.00		0	0			-	
Adjustment Amount (see instructions) HVPATI ENT ROUTINE SERVICE COST CENTERS Adjustment (sum of cols. 1 through 3, minus col. 4) Days 5 + col. 6) Program Days 30.00 03000 ADULTS & PEDIATRICS 0 1.00 7.00 8.00 31.00 03000 ADULTS & PEDIATRICS 0 0 7.057 30.00 31.00 03000 INTENSIVE CARE UNIT 0 3.638 0.00 1.152 31.00 40.00 SUBPROVIDER - IPF 0 0 2.681 0.00 2.053 11.00 42.00 O4200 SUBPROVIDER - IPF 0 0 2.681 0.00 2.053 11.00 200.00 Total (ines 30 through 199) Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00 25.352 10.262 200.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 Cost Center Description Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00 31.00 31.00 03000 INTENSIVE CARE UNIT 0 31.00 31.00		Swing-Bed	Total Costs	Total Patien	Per Diem (col		200.00
Amount (see instructions) 1 through 3, minus col. 4) 3 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
INPATI ENT ROUTI NE SERVICE COST CENTERS 0				buys	0 . 001. 0)		
INPATIENT ROUTINE SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 03000 ADULTS & PEDIATRICS 0 0 17,002 0.00 7,057 30.00 03100 INTENSIVE CARE UNIT 0 3.638 0.00 1,152 31.00 04000 SUBPROVIDER - IPF 0 0 0 0.00 2,681 0.00 2,053 41.00 04200 SUBPROVIDER - I RF 0 0 0 0.00 2,053 41.00 04200 SUBPROVIDER 1 RF 0 0 0 0.00 2,000 0 0.00 2,053 41.00 04200 SUBPROVIDER 1 RF 0 0 0 0.00 0 0.00 42.00 04300 NURSERY 0 0 2,031 0.00 0 43.00 43.00 43.00 43.00 0 20.00 0 25,352 10,262 200.00 0 0 30.00 31.00 30.00							
INPATI ENT ROUTI NE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 0 0 17,002 0.00 7,057 30.00 31. 00 03100 INTENSI VE CARE UNI T 0 3,638 0.00 1,152 31.00 40. 00 04000 SUBPROVI DER - IPF 0 0 0 0.00 20.00 0				6.00	7 00	8.00	
30.00 O3000 ADULTS & PEDIATRICS 0 17,002 0.00 7,057 30.00 31.00 O3100 INTENSIVE CARE UNIT 0 3,638 0.00 1,152 31.00 40.00 O4000 SUBPROVI DER - IPF 0 0 0 0.00 0 0 0 0.00 0	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
31.00 03100 INTENSIVE CARE UNIT 0 3,638 0.00 1,152 31.00 40.00 04000 SUBPROVI DER - IPF 0 0 0.00 0.00 0 40.00 41.00 O4000 SUBPROVI DER - I RF 0 0 2,681 0.00 2,053 41.00 42.00 O4200 SUBPROVI DER 0 0 0 0 0 42.00 43.00 O4300 NURSERY 0 0 2,031 0.00 0 43.00 200.00 Total (Lines 30 through 199) Inpatient Program Pass-Through 0 25,352 10,262 200.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRICS 0 31.00 31.00 03100 INTENSI VE CARE UNIT 0 31.00 31.00 31.00 03000 ADULTS & PEDI ATRICS 0 31.00 31.00 31.00 03100 INTENSI VE CARE UNIT 0 40.00 41.00 41.00 04000 SUBPROVI DER - I PF <		0	0	17.00	2 0.00	7 057	30.00
40.00 04000 SUBPROVI DER - IPF 0 0 0 0.00 0 40.00 41.00 04100 SUBPROVI DER - IRF 0 0 0 2,681 0.00 2,053 41.00 42.00 04200 SUBPROVI DER 0 0 0 0 0 0 0 42.00 43.00 04300 NURSERY 0 0 2,031 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 25,352 10,262 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 9.00 30.00 30.00 30300 ADULTS & PEDIATRICS 0 31.00 31.00 31.00 03100 INTENSI VE CARE UNIT 0 40.00 41.00 41.00 41.00 04200 SUBPROVI DER - I RF 0 42.00 42.00 43.00 42.00 04200 SUBPROVI DER - I RF 0 42.00 43.00 43.00		0	0				
41.00 04100 SUBPROVI DER - IRF 0 0 2,681 0.00 2,053 41.00 42.00 04200 SUBPROVI DER 0 0 0 0.00 0 42.00 43.00 04300 NURSERY 0 2,031 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 25,352 10,262 200.00 Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 9.00 9.00 30.00 30.00 30.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.0		0	0	0,00			
42.00 04200 SUBPROVI DER 0 0 0.00 0 42.00 43.00 04300 NURSERY 0 2,031 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 25,352 10,262 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 10,262 200.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 31.00 03000 ADULTS & PEDIATRICS 0 31.00 31.00 03100 INTENSI VE CARE UNIT 0 42.00 40.00 42.00 04100 SUBPROVI DER - I PF 0 42.00 43.00 42.00 04200 SUBPROVI DER - I RF 0 41.00 42.00 43.00 04300 NURSERY 0 0 42.00 43.00		0	0	2 69			
43.00 04300 200.00 NURSERY Total (lines 30 through 199) 0 2,031 0 0.00 0 0 43.00 10,262 43.00 20.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		0	0	2,00			
200.00 Total (lines 30 through 199) 0 25,352 10,262 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 31.00 31.00 31.00 31.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 41.00 41.00 41.00 41.00 41.00 42.00 43.00		0	0	2 02			
Impatient Impatient Program Pass-Through Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 100 03000 ADULTS & PEDIATRICS 03000 INTENSI VE CARE UNIT 0 40.00 SUBPROVI DER - I PF 0 0 41.00 SUBPROVI DER - I RF 42.00 04200 43.00 04300			0				
Program Pass-Through Cost (col. 7 x col. 8) 9.00 Program Pass-Through Cost (col. 7 x col. 8) Program Pass-Through Cost (col. 7 x col. 8) Program Pass-Through Sol (col. 8) Program Pass-Through Sol (col. 7 x col. 8) Program Pass-Through Sol (col. 7 x Sol (col. 7 x Sol (col. 7 x Sol (col. 8) Program Sol (col. 8) Program Sol (col. 7 x Sol (col. 8) Program Sol (col. 8)		Innationt	0	20, 30	2	10, 202	200.00
INPATI ENT ROUTI NE SERVICE COST CENTERS 9.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00	cost center bescription						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30000 ADULTS & PEDI ATRI CS 0 30.00 30.00 31.00 <							
col. 8) 9.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 9.00 30. 00 03000 ADULTS & PEDI ATRI CS 0 31. 00 03100 INTENSI VE CARE UNI T 0 40. 00 04000 SUBPROVI DER - I PF 0 41. 00 04100 SUBPROVI DER - I RF 0 42. 00 04200 SUBPROVI DER - I RF 0 43. 00 04300 NURSERY 0							
9.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 40.00 04000 SUBPROVIDER - IPF 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 42.00 04200 SUBPROVIDER - IRF 0 42.00 43.00 04300 NURSERY 0 43.00							
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS 0 30.00 31.00 O3100 NTENSI VE CARE UNIT 0 31.00 40.00 O4000 SUBPROVI DER - I PF 0 40.00 41.00 O4100 SUBPROVI DER - I RF 0 41.00 42.00 O4200 SUBPROVI DER 1 RF 0 42.00 43.00 O4300 NURSERY 0 43.00							
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 40. 00 04000 SUBPROVI DER - I PF 0 40. 00 41. 00 04100 SUBPROVI DER - I RF 0 41. 00 42. 00 04200 SUBPROVI DER 0 42. 00 43. 00 04300 NURSERY 0 43. 00	INDATIENT DOUTINE SEDVICE COST CENTEDS	9.00					
31.00 03100 INTENSIVE CARE UNIT 0 31.00 40.00 04000 SUBPROVI DER - I PF 0 40.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER - I RF 0 42.00 43.00 04300 NURSERY 0 43.00		0					30.00
40.00 04000 SUBPROVI DER - I PF 0 40.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER - I RF 0 43.00 04300 NURSERY 0 43.00		0					
41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER 0 42.00 43.00 04300 NURSERY 0 43.00		0					
42. 00 04200 SUBPROVI DER 0 42. 00 43. 00 43. 00 04300 NURSERY 0 43. 00 43. 00		0					
43. 00 04300 NURSERY 0 43. 00		0					
		0					
200.00 10tal (Thes so through 199) 0 200.00		0					
	200.00 Total (Tines 30 through 199)	I O					1200. OU

Heal th	Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTI THROUGH	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER I COSTS	RVICE OTHER PASS			Period: From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:	
				XVIII	Hospi tal	PPS	
	Cost Center Description				I Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
	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	C		0 0	0	54.00
57.00	05700 CT SCAN	0	C		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C)	0 0	0	59.00
60.00	06000 LABORATORY	0	C)	0 0	0	60.00
60.01	06001 ONCOLOGY	0	C)	0 0	0	60. 01
60. 02	06002 RADIATION ONCOLOGY	0	0)	0 0	0	60. 02
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
69.01	06901 CARDI AC REHAB	0	C		0 0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
0	OUTPATIENT SERVICE COST CENTERS			·		•	
90.00	09000 CLI NI C	0	C)	0 0	0	90.00
91.00	09100 EMERGENCY	0	C		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	C)	0 0	0	92.01
(OTHER REIMBURSABLE COST CENTERS			·		·	1
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	C		0 0	0	200. 00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Pre 11/26/2018 2:	
		Title	XVIII	Hospi tal	PPS	00 pm
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8 It	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	1		1	-1		
50.00 O5000 OPERATING ROOM	0	0		0 109, 664, 922	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 32, 109, 056		
57.00 05700 CT SCAN	0	0		0 33, 814, 830		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 3, 464, 705		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 9, 442, 482	0.00000	59.00
60. 00 06000 LABORATORY	0	0		0 18, 030, 485	0.000000	60.00
60. 01 06001 ONCOLOGY	0	0		0 6, 991, 136	0.000000	60.01
60. 02 06002 RADIATION ONCOLOGY	0	0		0 0	0.000000	60. 02
65. 00 06500 RESPI RATORY THERAPY	0	0		0 8, 783, 401	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 176, 147	0.00000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 11, 933, 508	0.00000	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 877, 054	0. 000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 82, 302, 328	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	I	0 1, 022, 120	0. 000000	90.00
91.00 09100 EMERGENCY	0	0		0 71, 027, 243	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 6, 397, 506	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0. 000000	92.01
OTHER REIMBURSABLE COST CENTERS]
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 406, 036, 923		200. 00

Health Financial Systems	MARION GENERAL	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Pre 11/26/2018 2:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	· · ·			-1		
50.00 O5000 OPERATI NG ROOM	0. 000000	12, 481, 967		0 17, 463, 523	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 028, 087		0 8, 311, 711	0	54.00
57.00 05700 CT SCAN	0. 000000	2, 523, 608		0 8, 885, 448	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	140, 701		0 1, 062, 823	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 413, 655		0 2, 597, 652	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 984, 350		0 1, 961, 230	0	60.00
60. 01 06001 ONCOLOGY	0. 000000	23, 576		0 3, 005, 152	0	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000	0		0 0	0	60. 02
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 357, 610		0 2, 038, 690	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	1, 122, 494		0 46, 791	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	1, 962, 356		0 2, 694, 839	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0 287, 477	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0, 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	4, 117, 863		0 36, 275, 292	0	73.00
OUTPATIENT SERVICE COST CENTERS	1					
90, 00 09000 CLINIC	0,000000	0		0 434,000	0	90.00
91.00 09100 EMERGENCY	0, 000000	5, 255, 449		0 12, 775, 947	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 1, 105, 235	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0, 000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS			1	<u> </u>	<u>_</u>	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		33, 411, 716		0 98, 945, 810	0	200.00
	· ·					

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 07/01/2017 To 06/30/2018	Part V Date/Time Pre	narod
				10 00/30/2018	11/26/2018 2:	
		Title	× XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.4700.40	47.440.500	1		0.005.004	
50. 00 05000 OPERATING ROOM	0. 173842			0 0	3, 035, 894	
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 273347			0 0	2, 271, 981	54.00
57.00 05700 CT SCAN	0. 047718			0 0	423, 996	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 254206			0 0	270, 176	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 337542			0 0	876, 817	59.00
60. 00 06000 LABORATORY	0. 664240			0 0	1, 302, 727	60.00
60. 01 06001 0NC0L0GY	0. 322103			0 0	967, 968	
60. 02 06002 RADI ATI ON ONCOLOGY	0.000000			0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	0. 417355			0 0	850, 857	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 295647			0 0	13, 834	1
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0. 202192			0 0	544, 875	69.00 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0 0	169, 862 0	71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			0 0	0	72.00
72.00 07200 TMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 187450			0 6,642	6, 799, 803	
OUTPATIENT SERVICE COST CENTERS	0. 167430	30, 273, 292		0 0, 042	0, 799, 803	/3.00
90. 00 09000 CLINIC	1. 108599	434,000		0 0	481, 132	90.00
91. 00 09100 EMERGENCY	0. 139237			0 0	1, 778, 885	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 502521			0 0	555, 404	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.00000		1	0 0	0	72.01
95. 00 09500 AMBULANCE SERVICES	0. 434565			0		95.00
200.00 Subtotal (see instructions)	0. 101000	98, 945, 810		0 6,642	20, 344, 211	
201.00 Less PBP Clinic Lab. Services-Program				0 0,012		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		98, 945, 810		0 6, 642	20, 344, 211	202.00

Heal th	Financial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORT	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Pre 11/26/2018 2:	
			Title	XVIII	Hospi tal	PPS	
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
		6.00	7.00	-			
	ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	I			
	05000 OPERATING ROOM	0	0				50.00
	05100 RECOVERY ROOM	0	0				51.00
	05400 RADI OLOGY-DI AGNOSTI C	0	C)			54.00
	05700 CT SCAN	0	C)			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (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 ONCOLOGY	0	0				60.01
60. 02	06002 RADIATION ONCOLOGY	0	0				60. 02
65.00	06500 RESPI RATORY THERAPY	0	C				65.00
66.00	06600 PHYSI CAL THERAPY	0	C				66.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	06901 CARDI AC REHAB	0	0				69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	1			72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 245				73.00
	OUTPATIENT SERVICE COST CENTERS	-1		1			
	09000 CLINIC	0	0	1			90.00
	09100 EMERGENCY	0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	C	1			92.01
	OTHER REI MBURSABLE COST CENTERS						95.00
95.00 200.00	09500 AMBULANCE SERVICES	0	1 045				95.00 200.00
200.00		0	1, 245				200.00
201.00	Only Charges						201.00
202.00		0	1, 245				202.00
202.00	met ondryes (The 200 - The 201)	, Ч	1, 240	1			1202.00

APPORTI ONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0011 Component CCN: 15-T011 Period: From 07/01/2017 To 06/30/2018 Worksheet D Part II Do 06/30/2018 Image: Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (from Wkst. C, Part I, col. 20) Ratio of Cost to Charges Inpatient Program (col umn 3 x col umn 4) Capital Costs (col umn 3 x col umn 4) 50.00 05000 OPERATING ROOM 05000 2,122,129 0 109,664,922 0 0.019351 0 62,184 1,203 1,203 50.00 50.00 51.00 05100 RCOVERY ROOM 0 1,245,127 32,109,056 32,00 4.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 0 52
ANCILLARY SERVICE COST CENTERS Component CCN: 15-T011 To 06/30/2018 Date/Time Prepared: 11/26/2018 2: 38 pm ANCILLARY SERVICE COST CENTERS Capi tal (from Wkst. B, Part II, col. 26) Total Charges (from Wkst. C, 26) Rati o of Cost to Charges (col. 1 + col. 2) Inpati ent Program (col umn 4) Capi tal Costs (col umn 4) Capi tal Costs (col umn 4) ANCILLARY SERVICE COST CENTERS 2, 122, 129 109, 664, 922 0.019351 62, 184 1, 203 50.00 50.00 05100 RECOVERY ROOM 2, 122, 129 109, 664, 922 0.019351 62, 184 1, 203 50.00 51.00 05100 RECOVERY ROOM 1, 245, 127 32, 109, 056 0.038778 37, 561 1, 457 54.00 54.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107, 334 3, 464, 705 0.038279 15, 993 495 58.00 58.00 05900 CARDI AC CATHETERIZATI ON 324, 149 9, 442, 482 0.034329 4.686 161 59.00 59.00 05900 CARDI AC CATHETERIZATI ON 324, 149 9, 442, 482 0.034329 4.686
ANCI LLARY SERVICE COST CENTERS Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (from Wkst. C, Part I, col. 26) Ratio of Cost to Charges Inpati ent Program Charges Capital Costs (col umn 3 x col umn 4) 50.00 05000 0PERATI NG ROOM 2, 122, 129 109, 664, 922 0.019351 62, 184 1, 203 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0.038778 37, 561 1, 457 54.00 54.00 05400 RADI LLARY SERVICE CANCE I MAGING (MRI) 107, 334 3, 464, 705 0.038778 37, 561 1, 457 54.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 107, 334 3, 464, 705 0.039779 15, 993 495 58.00 59.00 05900 CARILARY SERVICE REVICE CATHERERIZATION 324, 149 9, 442, 482 0.034329 4, 686 161 59.00 59.00 06000 LABORATORY 891, 335 18, 030, 485 0.049435 72, 626 3, 590 60.00
ANCI LLARY SERVICE COST CENTERS Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (rom Wkst. C, 8) Ratio of Cost to Charges Inpatient Program (col umn 3 x col umn 4) Capital Costs (col umn 3 x col umn 4) 50.00 05000 OPERATI NG ROOM 2, 122, 129 0 109, 664, 922 0 0.019351 0 62, 184 2, 184 1, 203 1, 203 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 0.019351 0 62, 184 1, 457 1, 203 50.00 50.00 54.00 05400 RADI LLARY SERVICE COST CENTERS 0 0 0 0 0.019351 0 62, 184 1, 203 1, 203 50.00 50.00 54.00 05400 RADI LLARY SERVICE COST CENTERS 0 0 0 0 0.019351 0 62, 184 1, 203 1, 203 50.00 50.00 54.00 05400 RADI LLARY SERVICE COST CENTERS 1, 245, 127 32, 109, 056 0.038778 0.038778 37, 561 1, 457 54.00 1, 457 54.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107, 334 3, 464, 705 0.03297 0.03329 18, 030, 485 0.049435 72, 626 3, 590 60.00
Cost Center Description Capital Related Cost (from Wkst. B, Part I, col. 26) Total Charges (from Wkst. C, Part I, col. 8) Ratio of Cost to Charges (col. 1 + col. 2) Inpatient Program Charges Capital Costs (col umn 3 x col umn 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 2,122,129 109,664,922 0.019351 62,184 1,203 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 54.00 05400 RADI LAGNOSTIC 1,245,127 32,109,056 0.038778 37,561 1,457 54.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107,334 3,464,705 0.030979 50,513 166 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324,149 9,442,482 0.034329 4,686 161 59.00 60.00 06000 LABORATORY 891,335 18,030,485 0.049435 72,626 3,590 60.00
Related Cost (from Wkst. B, Part II, col. 26) (from Wkst. C, Part I, col. 8) to Charges (col. 1 ÷ col. 2) Program Charges (col umn 3 x col umn 4) ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 2, 122, 129 109, 664, 922 0.019351 62, 184 1, 203 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 245, 127 32, 109, 056 0.038778 37, 561 1, 457 54.00 57.00 05700 CT SCAN 111, 296 33, 814, 830 0.003291 50, 513 166 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107, 334 3, 464, 705 0.030979 15, 993 495 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324, 149 9, 442, 482 0.034329 4, 686 161 59.00 60.00 06000 LABORATORY 891, 335 18, 030, 485 0.049435 72, 626 3, 590 60.00
ANCI LLARY SERVICE COST CENTERS Column 4) Column 4) 26) 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 2,122,129 109,664,922 0.019351 62,184 1,203 50.00 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,245,127 32,109,056 0.038778 37,561 1,457 54.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107,334 3,464,705 0.030979 15,993 495 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324,149 9,442,482 0.034329 4,686 161 59.00 60.00 60.00 60.0049435 72,626 3,590 60.00
Part II, col. 8) 2) 3 4 26) 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 2,122,129 109,664,922 0.019351 62,184 1,203 50.00 50.00 05100 RECOVERY ROOM 0 0 0.000000 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,245,127 32,109,056 0.038778 37,561 1,457 54.00 57.00 05700 CT SCAN 111,296 33,814,830 0.003291 50,513 166 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107,334 3,464,705 0.030979 15,993 495 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324,149 9,442,482 0.034329 4,686 161 59.00 60.00 06000 LABORATORY 891,335 18,030,485 0.049435 72,626 3,590 60.00
26) 7 6 6 6 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2,122,129 109,664,922 0.019351 62,184 1,203 50.00 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,245,127 32,109,056 0.038778 37,561 1,457 54.00 57.00 05700 CT SCAN 111,296 33,814,830 0.003291 50,513 166 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107,334 3,464,705 0.030979 15,993 495 58.00 59.00 05900 CADI AC CATHETERI ZATI ON 324,149 9,442,482 0.034329 4,686 161 59.00 60.00 06000 LABORATORY 891,335 18,030,485 0.049435 72,626 3,590 60.00
I.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2,122,129 109,664,922 0.019351 62,184 1,203 50.00 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,245,127 32,109,056 0.038778 37,561 1,457 54.00 57.00 05700 CT SCAN 111,296 33,814,830 0.003291 50,513 166 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107,334 3,464,705 0.030979 15,993 495 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324,149 9,442,482 0.034329 4,686 161 59.00 60.00 06000 LABORATORY 891,335 18,030,485 0.049435 72,626 3,590 60.00
50.00 05000 OPERATING ROOM 2, 122, 129 109, 664, 922 0.019351 62, 184 1, 203 50.00 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 245, 127 32, 109, 056 0.038778 37, 561 1, 457 54.00 57.00 05700 CT SCAN 111, 296 33, 814, 830 0.003291 50, 513 166 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107, 334 3, 464, 705 0.030979 15, 993 495 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324, 149 9, 442, 482 0.034329 4, 686 161 59.00 60.00 06000 LABORATORY 891, 335 18, 030, 485 0.049435 72, 626 3, 590 60.00
51.00 05100 RECOVERY ROOM 0 0.000000 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 245, 127 32, 109, 056 0.038778 37, 561 1, 457 54.00 57.00 05700 CT SCAN 111, 296 33, 814, 830 0.003291 50, 513 166 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107, 334 3, 464, 705 0.030979 15, 993 495 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324, 149 9, 442, 482 0.034329 4, 686 161 59.00 60.00 06000 LABORATORY 891, 335 18, 030, 485 0.049435 72, 626 3, 590 60.00
54. 0005400RADI OLOGY-DI AGNOSTI C1, 245, 12732, 109, 0560.03877837, 5611, 45754. 0057. 0005700CT SCAN111, 29633, 814, 8300.00329150, 51316657. 0058. 0005800MAGNETI C RESONANCE I MAGI NG (MRI)107, 3343, 464, 7050.03097915, 99349558. 0059. 0005900CARDI AC CATHETERI ZATI ON324, 1499, 442, 4820.0343294, 68616159. 0060. 0006000LABORATORY891, 33518, 030, 4850.04943572, 6263, 59060. 00
57. 0005700CT SCAN111, 29633, 814, 8300. 00329150, 51316657. 0058. 0005800MAGNETI C RESONANCE I MAGI NG (MRI)107, 3343, 464, 7050. 03097915, 99349558. 0059. 0005900CARDI AC CATHETERI ZATI ON324, 1499, 442, 4820. 0343294, 68616159. 0060. 0006000LABORATORY891, 33518, 030, 4850. 04943572, 6263, 59060. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 107, 334 3, 464, 705 0. 030979 15, 993 495 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 324, 149 9, 442, 482 0. 034329 4, 686 161 59. 00 60. 00 06000 LABORATORY 891, 335 18, 030, 485 0. 049435 72, 626 3, 590 60. 00
59. 00 05900 CARDI AC_CATHETERI ZATI ON 324, 149 9, 442, 482 0. 034329 4, 686 161 59. 00 60. 00 06000 LABORATORY 891, 335 18, 030, 485 0. 049435 72, 626 3, 590 60. 00
60.00 06000 LABORATORY 891, 335 18, 030, 485 0. 049435 72, 626 3, 590 60. 00
60. 01 1060011 0NC0L0GY 1 42. 7931 6. 991. 1361 0. 0061211 5321 31 60. 01
60. 02 06002 RADIATION ONCOLOGY 0 0 0.000000 0 0 60. 02
65. 00 06500 RESPI RATORY_THERAPY 315, 675 8, 783, 401 0. 035940 99, 295 3, 569 65. 00
66. 00 06600 PHYSI CAL THERAPY 109, 336 10, 176, 147 0. 010744 2, 127, 900 22, 862 66. 00
69. 00 06900 ELECTROCARDI OLOGY 465, 740 11, 933, 508 0. 039028 55, 204 2, 155 69. 00
69. 01 06901 CARDI AC REHAB 81, 245 877, 054 0. 092634 0 0 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0.000000 0 0 71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 0 0 72.00
73. 00 OT300 DRUGS CHARGED TO PATIENTS 410, 726 82, 302, 328 0. 004990 357, 172 1, 782 73. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 169, 897 1, 022, 120 0. 166220 0 0 90. 00
91. 00 09100 EMERGENCY 849, 871 71, 027, 243 0. 011965 71, 113 851 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 6, 397, 506 0. 000000 0 92. 00
92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0.000000 0 92. 01
OTHER REIMBURSABLE COST CENTERS
95.00 09500 AMBULANCE SERVICES 95.00
200.00 Total (Lines 50 through 199) 7, 246, 653 406, 036, 923 2, 954, 779 38, 294 200.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	VICE OTHER PAS	S Provider C		Peri od:	Worksheet D		
THROUGH COSTS				From 07/01/2017			
		Component	CCN: 15-T011	To 06/30/2018	Date/Time Pre 11/26/2018 2:		
		Title	e XVIII	Subprovider -	PPS		
				I RF			
Cost Center Description				Allied Health	Allied Health		
	Anestheti st	Post-Stepdown		Post-Stepdown			
	Cost	Adjustments		Adjustments			
	1.00	2A	2.00	3A	3.00		
ANCI LLARY SERVI CE COST CENTERS	1	1	1				
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 RADIATION ONCOLOGY	0	0		0 0	0	60. 02	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00	
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS		_		_			
90. 00 09000 CLINIC	0	0		0 0	0	90.00	
91.00 09100 EMERGENCY	0	0		0 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01	
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVI CES						95.00	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00	

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period: Worksheet D		
THROUGH COSTS		Component		From 07/01/2017 To 06/30/2018		norod.
		component	CCN: 15-T011	10 06/30/2018	11/26/2018 2:	
		Title	XVIII	Subprovider -	PPS	
	r			IRF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	5	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
	4.00	F 00	4)	7.00	8,00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM	0	0		109, 664, 922	0. 000000	E0 00
51. 00 05100 RECOVERY ROOM	0	0		0 109,004,922	0. 000000	
54. 00 105400 RADI OLOGY-DI AGNOSTI C	0	0		32, 109, 056		
57. 00 05700 CT SCAN	0	0		33, 814, 830		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		3, 464, 705		
59. 00 05900 CARDIAC CATHETERIZATION	0	0		9, 442, 482		
60. 00 06000 LABORATORY	0			18, 030, 485		•
60. 01 06001 0NC0L0GY	0			6, 991, 136		
60. 02 06002 RADI ATI ON ONCOLOGY	0			0, 771, 130	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0			8, 783, 401	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0			10, 176, 147		
69. 00 06900 ELECTROCARDI OLOGY	0	0		11, 933, 508		
69. 01 06901 CARDI AC REHAB	0	0		877,054		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		82, 302, 328		
OUTPATI ENT SERVI CE COST CENTERS		-				1
90. 00 09000 CLI NI C	0	0		1, 022, 120	0.00000	90.00
91. 00 09100 EMERGENCY	0	0		71, 027, 243		•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		6, 397, 506	0. 000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0. 000000	92.01
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		406, 036, 923		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-001 Component CCN: 15-1011 Period: From 07/01/2017 To 06/30/2018 Worksheet D To 06/30/2018 Image: Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col.) Inpatient Program Pass-Through Charges Inpatient Program Pass-Through Costs (col. 9 x col. 10) Outpatient Program Pass-Through Costs (col. 9 x col. 12) ANCILLARY SERVICE COST CENTERS 0.000000 62,184 0 0 0 0 50.00 50.00 05000 (DECOVERY ROM 0 00000 0.000000 0 11.00 12.00 13.00 51.00 05100 RECOVERY ROM 0 000000 0 0 0 0 51.00 50.00 05000 CARCHAC CATHETER JATI NO NOCULOY 0.000000 55.51 0 0 55.00 50.00 05000 CARDAC CATHETER JATI NO NOCULOY 0.000000 56.51.00 57.00 57.00 50.00 05000 CARDAC CATHETER JATI NO NOCULOY 0.000000 72.626 0 0 58.00	Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Ancount cool of Component CON: 15-T011 To 06/30/2018 Date/Time Propared: 11/26/2018 2:38 pm Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Unpatient Program Charges Outpatient Program Charges 50:00 00 05000 0 0 0 0 0 0 50:00 00 05000 0	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	Provider CO	CN: 15-0011			
Anci LLARY SERVICE COST CENTERS Outpatient to Charges (Col 6 + col. 7) Inpatient Program (Charges) Inpatient Program (Charges) Inpatient Program (Charges) Outpatient Program (Charges) Outpatient Program (Charges) Inpatient Program (Charges) Inpatient Program (Charges) <thinpatient (Charges)</thinpatient 	THROUGH COSTS		Company of the	00N 15 T011			
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Outpatient Program Charges 50.00 05000 (PERATING ROM 0.000000 62, 184 0 0 0 50.00 50.00 05000 (PERATING ROM 0.000000 53.00 51.00 51.00 51.00 51.00 51.00 05700 CT SCAN 0.000000 15.993 0 0 58.00 58.00 59.00 05900 (ARDIA C CATHETERIZATION 0.000000 15.993 0 0 58.00 59.00 59.00 59.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00			component (JUN: 15-1011	10 06/30/2018	11/26/2018 2	pared: 38 nm
Cost Center Description Outpatient Ratio of Cost to Charges Inpatient Program Charges Unpatient Program Charges Outpatient Program Charges Outpatient Program Charges Program Charges ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 30.00 50.00 05000 (PERATING ROM 0.000000 62.184 0 0 0 13.00 51.00 05100 (RECOVERY ROM 0.000000 37.561 0 0 0 51.00 54.00 05400 (RADI OLGY-DI AGNOSTI C 0.000000 50.513 0 0 51.00 59.00 05000 (ARGIAC CATHERE I MAGI NG (MRI) 0.000000 50.513 0 0 55.00 60.00 06000 (LABORATORY 0.000000 52.32 0 0 60.01 60.01 060000 (SOLGREAT HERI ZATION 0.000000 53.22 0 0 66.00 60.00 06000 (DARDIAC REHIAR TOR NOT HERAPY 0.000000 0 0 66.00 60.00 06000 (DARDIAC REHIAR TOR NOT HERAPY 0.000000 0 0 <td></td> <td></td> <td>Title</td> <td>XVIII</td> <td>Subprovider -</td> <td></td> <td>00 pm</td>			Title	XVIII	Subprovider -		00 pm
Ratio of Cost to Charges Program Charges Program Pass-Through Costs (col. 8 Program Pass-Through Costs (col. 9 Program Pass-Through Costs (col. 10) Program Pass-Through Costs (col. 10) Program Pass-Through Costs (col. 10) Program Pass-Through Costs (col. 10) Program To cost (col. 12) Program Pass-Through Costs (col. 10) Program To cost (col. 12) Program Pass-Through Costs (col. 10) Program To cost (col. 12) Program To cost (col 12) Program To cost (col 12) Program To cost (col 12) Program To cost (c							
to Charges (col. 6 + col.) Charges (col. 6 + col.) Pass-Through Costs (col. 8 x col. 10) Pass-Through Costs (col. 9 x col. 12) ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 0PERATING ROOM 0.000000 62,184 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 54.00 05700 CT SCAN 0.000000 15.10 0 57.00 57.00 57.00 57.00 57.00 57.00 58.00 0 0 58.00 58.00 59.00 59.90 0 0 58.00 58.00 59.00 59.00 59.00 0 59.00 59.20 0 0 60.01	Cost Center Description		Inpati ent	I npati ent		Outpati ent	
ANCI LLARY SERVICE COST CENTERS Costs (col., 8 7) Costs (col., 6 x col., 10) Costs (col., 9 x col., 12) ANCI LLARY SERVICE COST CENTERS 0 <		Ratio of Cost	Program				
7) x col 10) x col 12) 9.00 10.00 11.00 12.00 13.00 50.00 05000 0PERATING ROM 0.000000 62,184 0 0 0 51.00 51.00 05400 0PERATING ROM 0.000000 0 0 0 51.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.000000 37,561 0 0 0 57.00 57.00 05700 CT SCAN 0.000000 55,513 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI 0N 0.000000 72,626 0 0 0 58.00 60.01 0KOCLOGY 0.000000 72,626 0 0 0 60.01 60.01 0KOCLOGY 0.000000 72,626 0 0 60.01 60.02 65.00 06500 RESPI RATORY THERAPY 0.000000 72,790 0 0 66.00 60.01 0Se000 MAGRED TO PATI ENTS 0.000000 0 <td< td=""><td></td><td></td><td>Charges</td><td></td><td></td><td></td><td></td></td<>			Charges				
P. 00 10.00 11.00 12.00 13.00 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 (PERATI NG ROOM 0.000000 62,184 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 37,561 0 0 57.00 57.00 CT SCAN 0.000000 50,513 0 0 58.00 59.00 OS900 CARDI AC CATHETERI ZATI ON 0.000000 15,993 0 0 58.00 60.00 CABORATORY 0.000000 72,626 0 0 0 60.00 60.01 OGOD LABORATORY 0.000000 532 0 0 66.01 60.02 GABORATORY 0.000000 92,295 0 0 66.02 60.01 NCLLORY 0.000000 92,295 0 0 66.00 60.02 DEGORERATATORY 0.0000000 0					8		
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 0PERATI NG ROM 0.000000 62, 184 0 0 0 50. 00 51. 00 05100 RECOVERY ROM 0.000000 0 0 0 0 51. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 37, 561 0 0 0 54. 00 57. 00 05700 CT SCAN 0.000000 15, 993 0 0 0 57. 00 58. 00 05800 MARENTI C RESONANCE I MAGI NG (MRI) 0.000000 15, 993 0 0 0 57. 00 59. 00 05900 CARDATORY 0.000000 15, 993 0 0 60. 00 60							
50.00 05000 OPERATING ROM 0.000000 62, 184 0 0 0 50.00 51.00 05100 RECOVERY ROM 0.000000 0 0 0 0 51.00 54.00 05100 RECOVERY ROM 0.000000 37, 561 0 0 0 51.00 57.00 05700 CT SCAN 0.000000 15, 993 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 15, 993 0 0 58.00 59.00 0.000000 4, 686 0 0 59.00 60.00 0 60.00		9.00	10.00	11.00	12.00	13.00	
51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.000000 37,561 0 0 54.00 57.00 05700 CT SCAN 0.000000 50,513 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 15,993 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 72,626 0 0 60.00 60.01 06001 0NCOLOGY 0.000000 532 0 0 60.01 60.02 66000 RESPI RATORY THERAPY 0.000000 99.295 0 0 65.00 66.00 06000 PHYSI CAL THERAPY 0.000000 2,127,900 0 66.00 66.00 69.01 06900 LECTROCARDI OLOGY 0.000000 0 0 0 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
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57.00 05700 CT SCAN 0.000000 50,513 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 15,993 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 4,686 0 0 0 60.00 60.00 06001 NOCLOGY 0.000000 72,626 0 0 0 60.00 60.01 06001 NOCLOGY 0.000000 532 0 0 60.01 60.01 60.02 RADIATION ONCOLOGY 0.000000 0 0 0 60.02 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 0 0 0 66.00 69.00 0 0 66.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.01 69.01 69.01 69.01 69.01 69.01 69.01 69.01 71.00 0 0 0 <			0		0 0	0	
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59.00 05900 CARDIAC CATHETERIZATION 0.000000 4,686 0 0 0 59.00 60.00 06000 LABORATORY 0.000000 72,626 0 0 0 60.00 60.01 06001 ONCOLOGY 0.000000 532 0 0 0 60.01 60.02 6002 RADIATION ONCOLOGY 0.000000 0 0 0 60.02 65.00 06500 RESPIRATORY THERAPY 0.000000 99,295 0 0 0 65.00 66.00 06901 CARDIAC REHAB 0.000000 2,127,900 0 0 66.00 66.00 69.01 06901 CARDIAC REHAB 0.000000 0 0 0 69.00 69.01 CARDIAC REHAB 0.000000 0 0 0 0 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 73.00 0					0 0	0	
60.00 06000 LABORATORY 0.000000 72,626 0 0 0 60.00 60.01 06001 0NCOLOGY 0.000000 532 0 0 0 60.01 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 0					0 0	0	
60.01 06001 0NCOLOGY 0.00000 532 0 0 60.01 60.02 06002 RADIATION ONCOLOGY 0.000000 0 <td< td=""><td></td><td></td><td></td><td></td><td>0 0</td><td>0</td><td>59.00</td></td<>					0 0	0	59.00
60. 02 06002 RADI ATI ON ONCOLOGY 0.000000 0	60. 00 06000 LABORATORY				0 0	0	60.00
65.00 06500 RESPI RATORY THERAPY 0.000000 99,295 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 2,127,900 0 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 55,204 0 0 0 69.00 69.01 06901 CARDI AC REHAB 0.000000 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL 0.000000 0 0 0 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 91.00 DSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 92.01 92.01 DSERVATI ON BEDS (DI STI	60. 01 06001 0NC0L0GY	0. 000000	532		0 0	0	60. 01
66.00 06600 PHYSI CAL THERAPY 0.000000 2,127,900 0 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 55,204 0 0 0 69.00 69.01 06901 CARDI AC REHAB 0.000000 0 0 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 357,172 0 0 0 73.00 00000 09000 CLI NI C 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 92.01 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 92.01 92.01 0BSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 0 0 92.01	60. 02 06002 RADIATION ONCOLOGY	0.000000	0		0 0	0	60. 02
69.00 06900 ELECTROCARDI OLOGY 0.000000 55,204 0 0 0 69.00 69.01 06901 CARDI AC REHAB 0.000000 0 0 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 357,172 0 0 0 73.00 00000 09100 CLI NI C 0.000000 0 0 0 90.00 90.00 09000 CLI NI C 0.000000 0 0 91.00 91.00 92.00	65. 00 06500 RESPI RATORY THERAPY	0.000000	99, 295		0 0	0	65.00
69. 01 06901 CARDI AC REHAB 0.000000 0 0 0 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 357, 172 0 0 0 73. 00 00000 CLI NI C 0 0.000000 357, 172 0 0 0 73. 00 01000 09000 CLI NI C 0.000000 0 0 0 90. 00 90. 00 09000 CLI NI C 0.000000 0 0 91. 00 92. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 01 <	66. 00 06600 PHYSI CAL THERAPY	0.000000	2, 127, 900		0 0	0	66.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 357,172 0 0 0 73.00 0UTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 71,113 0 0 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 92.00 92.00 92.01 09201 DBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.01 92.01 09201 DBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 92.01 92.01 07HER REI MBURSABLE COST CENTERS 95.00 95.00 95.00 95.00 95.00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	55, 204		0 0	0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 357,172 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 71,113 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 0 92.01 07HER REIMBURSABLE COST CENTERS UTHER UTHER REIMBURSABLE COST CENTERS 95.00 95.00 95.00 95.00	69. 01 06901 CARDI AC REHAB	0. 000000	0		0 0	0	69.01
73.00 07300 DRUGS CHARGED TO PATIENTS 0.00000 357,172 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.00000 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 71,113 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.00 92.01 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.01 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
90.00 09000 CLINIC 0.00000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 71,113 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 0 92.00 92.01 OTHER REI MBURSABLE COST CENTERS 95.00 950.0 MBULANCE SERVICES 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	357, 172		0 0	0	73.00
91.00 09100 EMERGENCY 0.000000 71,113 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 0 92.00 92.01 OTHER REI MBURSABLE COST CENTERS 0 0 0 92.01 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00	OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 0 0 0 92.00 92.01 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00	90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 0 0 92. 01 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00	91.00 09100 EMERGENCY	0. 000000	71, 113		0 0	0	91.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	92.00
95.00 09500 AMBULANCE SERVICES 95.00	92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0		0 0	0	92.01
	OTHER REIMBURSABLE COST CENTERS	· · ·					1
200.00 Total (lines 50 through 199) 2,954,779 0 0 0 200.00	95.00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)		2, 954, 779		0 0	0	200. 00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period: From 07/01/2017	Worksheet D-1	
			To 06/30/2018	11/26/2018 2:	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS			17.000	
00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			17, 002 17, 002	
00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	
00	do not complete this line.		-	14,000	
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	14, 022	
	reporting period	5, 5			
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	- 31 of the cost	0	7
	reporting period			-	
00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	7, 057	9
. 00	newborn days)	only (including private)	and ava	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		oom days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private)	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
. 00	through December 31 of the cost reporting period		te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Proc			0	14
. 00	Total nursery days (title V or XIX only)	, (0	15
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 (of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	cos ofter December 21 of	the cost	0.00	10
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through December 31 of	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction			18, 342, 064	
. 00	Swing-bed cost applicable to SNF type services through Decem 5×10^{-1} x line 17)	ber 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportio	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
. 00	x line 20)			0	20
. 00 . 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		19 242 044	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 MITHUS TTHE 20)		18, 342, 064	27
	General inpatient routine service charges (excluding swing-b	ed and observation bed cl	narges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	'÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	-		0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		rtions)	0.00	
	Average per diem private room cost differential (line 32 m Average per diem private room cost differential (line 34 x l			0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	18, 342, 064	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD			1.070.65	
	Adjusted general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x lin			1, 078. 82 7, 613, 233	
-	Medically necessary private room cost applicable to the Prog			0,013,233	1
. 00	Total Program general inpatient routine service cost (line 3	9 + line 40)		7, 613, 233	1 11

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	ON GENERAL HOSPITAL Provider CCN: 15-	0011 Peri od:	u of Form CMS- Worksheet D-1				
		From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:				
Cost Center Description	ent CostInpatient DaysDiem (co	age Per Program Days	PPS Program Cost (col. 3 x col. 4) 5.00				
42.00 NURSERY (title V & XIX only)	0 0	0.00 0	0	42.00			
Intensi ve Care Type Inpati ent Hospital Units43.00INTENSI VE CARE UNIT44.00CORONARY CARE UNIT45.00BURN INTENSI VE CARE UNIT46.00SURGI CAL INTENSI VE CARE UNIT47.00OTHER SPECI AL CARE (SPECI FY)	, 471, 065 3, 638	1, 503. 87 1, 152	1, 732, 458	43.00 44.00 45.00 46.00 47.00			
Cost Center Description			1 00				
48.00 Program inpatient ancillary service cost (Wkst	3 col 3 line 200)		1.00 7,208,836	48.00			
49.00 Total Program inpatient costs (sum of lines 41			16, 554, 527	•			
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpat	routine services (from Wkst.	D, sum of Parts I and	1, 409, 438	50.00			
51.00 Pass through costs applicable to Program inpat and IV)	ancillary services (from Wks	st. D, sum of Parts II	661, 708	51.00			
52.00 Total Program excludable cost (sum of lines 50	51)		2, 071, 146	52.00			
53.00 Total Program inpatient operating cost excludi medical education costs (line 49 minus line 52	apital related, non-physician	anesthetist, and	14, 483, 381	53.00			
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges			0	54.00			
55.00 Target amount per discharge				55.00			
56.00 Target amount (line 54 x line 55)			0	56.00			
57.00 Difference between adjusted inpatient operation	st and target amount (line 56	o minus line 53)	0				
58.00 Bonus payment (see instructions)			0				
59.00 Lesser of lines 53/54 or 55 from the cost repo market basket	g period ending 1996, updated	and compounded by the	0.00	59.00			
60.00 Lesser of lines 53/54 or 55 from prior year co 61.00 If line 53/54 is less than the lower of lines which operating costs (line 53) are less than	50% of the amount by	0. 00 0	•				
	amount (line 56), otherwise enter zero (see instructions)						
63.00 Allowable Inpatient cost plus incentive paymen	e instructions)		0	63.00			
64.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	ough December 31 of the cost	reporting period (See	0	64.00			
65.00 Medicare swing-bed SNF inpatient routine costs instructions) (title XVIII only)	er December 31 of the cost re	eporting period (See	0	65.00			
66.00 Total Medicare swing-bed SNF inpatient routine CAH (see instructions)	ts (line 64 plus line 65)(tit	le XVIII only). For	0	66.00			
67.00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	5		0				
68.00 Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)		ost reporting period	0				
69.00 Total title V or XIX swing-bed NF inpatient ro PART III - SKILLED NURSING FACILITY, OTHER NUR			0	69.00			
70.00 Skilled nursing facility/other nursing facilit	•	ine 37)		70.00			
71.00 Adjusted general inpatient routine service cos	diem (line 70 ÷ line 2)			71.00			
72.00 Program routine service cost (line 9 x line 71 73.00 Medically necessary private room cost applicab	Drogram (line 14 v line 25)			72.00			
73.00 Medically necessary private room cost applicab 74.00 Total Program general inpatient routine servic	5			73.00			
75.00 Capital -related cost allocated to inpatient ro 26, line 45)	. ,	eet B, Part II, column		75.00			
76.00 Per diem capital-related costs (line 75 ÷ line				76.00			
77.00 Program capital -related costs (line 9 x line 7	771			77.00			
78.00 Inpatient routine service cost (line 74 minus79.00 Aggregate charges to beneficiaries for excess				78.00			
80.00 Total Program routine service costs for compar	,	e 78 minus line 79)		80.00			
81.00 Inpatient routine service cost per diem limita		······································		81.00			
82.00 Inpatient routine service cost limitation (lin				82.00			
83.00 Reasonable inpatient routine service costs (se				83.00			
84.00 Program inpatient ancillary services (see inst 85.00 Utilization review - physician compensation (s				84.00 85.00			
86.00 Total Program inpatient operating costs (sum o				85.00			
PART IV - COMPUTATION OF OBSERVATION BED PASS				1 33			
87.00 Total observation bed days (see instructions)			2, 980	•			
88.00 Adjusted general inpatient routine cost per di			1,078.82	•			
89.00 Observation bed cost (line 87 x line 88) (see	uctions)		3, 214, 884	07.00			

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: Worksheet D- From 07/01/2017		
					Date/Time Pre 11/26/2018 2:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 877, 195	18, 342, 064	0. 15686	3 3, 214, 884	504, 296	90.00
91.00 Nursing School cost	0	18, 342, 064	0. 00000	0 3, 214, 884	0	91.00
92.00 Allied health cost	0	18, 342, 064	0. 00000	0 3, 214, 884	0	92.00
93.00 All other Medical Education	0	18, 342, 064	0. 00000	0 3, 214, 884	0	93.00

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period: From 07/01/2017	Worksheet D-1	
		Component CCN: 15-T011	To 06/30/2018	Date/Time Pre 11/26/2018 2:	
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		2, 681	1 1.
00	Inpatient days (including private room days, excluding swing-			2, 681	
00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	
00	do not complete this line.			2 (01	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	2, 681 0	
00	reporting period			0	ľ
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	am dave) through December	21 of the cost	0	7
00	reporting period	Sin days) thi ough becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	to the Dreamen (avaluated	cwing bod and		
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	i swing-bea ana	2, 053	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private r	oom days)	0	10
~~	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, et al. 1997)		oom days) atter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost	0.00	17
	reporting period	-			
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
00	reporting period	an often December 21 of t	he east	0.00	1 20
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter December 31 or t	ne cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ns)		3, 631, 404	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	ber 31 of the cost report	ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	na period (line 6	0	23
. 00	x line 18)	1 31 01 the cost reportin	ig period (inne o	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)	I	3, 631, 404	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)	Line 20		0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- TINE 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
	Average per diem private room cost differential (line 34×16	ine 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 3, 631, 404	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILICTMENTS			-
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 354. 50	38
	Program general inpatient routine service cost (line 9 x line			2, 780, 789	
. 00	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	
. 00	Total Program general inpatient routine service cost (line 39	9 + line 40)		2, 780, 789	41

ealth Financi CMPUTATION OI	al Systems FINPATIENT OPERATING COST	MARION GENERAL	HOSPI TAL Provi der C	CN: 15-0011	In Lie Period:	u of Form CMS- Worksheet D-1	
				CCN: 15-T011	From 07/01/2017 To 06/30/2018	Date/Time Pre	epare
			Title	e XVIII	Subprovider -	11/26/2018 2: PPS	:38 p
C	ost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient CostIn	patient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
	(title V & XIX only)	1.00	2.00 C	3.00	4.00	5.00) 42.
Intensi	ve Care Type Inpatient Hospital Units					1	
1	VE CARE UNIT RY CARE UNIT	0	C	0.	00 00	C) 43. 44.
1	ITENSI VE CARE UNI T						44.
1	AL INTENSIVE CARE UNIT						46.
	SPECIAL CARE (SPECIFY) ost Center Description						47.
.00 Program	n inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1.00 836,111	1 48.
.00 Total F	Program inpatient costs (sum of lines			ons)		3, 616, 900	
	ROUGH COST ADJUSTMENTS prough costs applicable to Program inp	atient routine se	rvices (from	n Wkst. D, su	n of Parts I and	461, 453	3 50
.00 Pass th	nrough costs applicable to Program inp	atient ancillary	services (fr	om Wkst D	sum of Parts II	38, 294	4 51
and IV)		5					
	Program excludable cost (sum of lines Program inpatient operating cost exclu		ted, non-phy	sician anesti	netist, and	499, 747 3, 117, 153	
medi cal	education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION		,				
	n di scharges					C	54
	amount per discharge amount (line 54 x line 55)					0.00	
	ence between adjusted inpatient operat	ing cost and targ	et amount (I	ine 56 minus	line 53)		
.00 Bonus p	payment (see instructions)	0 0				C C	
.00 Lesser market	of lines 53/54 or 55 from the cost re	porting period en	ding 1996, ι	ipdated and c	ompounded by the	0.00	59
1	of lines 53/54 or 55 from prior year	cost report, upda	ted by the m	arket basket		0.00	60 0
	e 53/54 is less than the lower of line perating costs (line 53) are less that					C	61
	(line 56), otherwise enter zero (see		(TTHES 54 X	60), 01 1% 0	i the target		
	payment (see instructions)					C	
	Die Inpatient cost plus incentive paym INPATIENT ROUTINE SWING BED COST	ent (see instruct	i ons)			C) 63
	re swing-bed SNF inpatient routine cos tions)(title XVIII only)	ts through Decemb	er 31 of the	e cost report	ng period (See	C	64
. 00 Medi car	re swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reporting	g period (See	C	65
	tions)(title XVIII only) Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 6	5)(title XVI	ll onlv). For	с С	66
CAH (se	e instructions)		•		5.	C	47
	/or XIX swing-bed NF inpatient routin 2 x line 19)	e costs through D	ecember 31 c	I the cost h	eporting period		67
	/or XIX swing-bed NF inpatient routin 3 x line 20)	e costs after Dec	ember 31 of	the cost rep	orting period	C	68
0.00 Total t	itle V or XIX swing-bed NF inpatient I - SKILLED NURSING FACILITY, OTHER N					C	69
	I nursing facility/other nursing facil	·)		70
	ed general inpatient routine service c		e 70 ÷ line	2)			71
	n routine service cost (line 9 x line ly necessary private room cost applic		line 14 x li	ne 35)			72
.00 Total F	Program general inpatient routine serv	ice costs (line 7	2 + line 73)	,			74
.00 Capital 26, lir	-related cost allocated to inpatient ne 45)	routine service c	osts (from V	lorksheet B, I	Part II, column		75
1	em capital-related costs (line 75 ÷ li n capital-related costs (line 9 x line						76
5	ent routine service cost (line 74 minu						78
00 0	te charges to beneficiaries for exces						79
	Program routine service costs for comp ent routine service cost per diem limi		ιιιmitatior	ı (ııne /8 miı	nus iine 79)		80
	ent routine service cost limitation (I						82
1	ble inpatient routine service costs (83
U U	n inpatient ancillary services (see in ntion review - physician compensation)				84
.00 Total F	Program inpatient operating costs (sum	of lines 83 thro					86
	- COMPUTATION OF OBSERVATION BED PAS						1 07
	observation bed days (see instructions ed general inpatient routine cost per		ine 2)			0.00	
	ation bed cost (line 87 x line 88) (se		,				89

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2017	Worksheet D-1	
		Component (Component CCN: 15-T011		Date/Time Prep 11/26/2018 2:3	
		Title	XVIII	Subprovider - IRF	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	602, 601	3, 631, 404	0. 16594	2 0	0	90.00
91.00 Nursing School cost	0	3, 631, 404	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 631, 404	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 631, 404	0.00000	0 0	0	93.00

	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST COST	Provider CCN: 15-0011	Period: From 07/01/2017	u of Form CMS-2 Worksheet D-1	
			To 06/30/2018	11/26/2018 2:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS			17,000	1
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			17, 002 17, 002	2
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b	oed days)		14, 022	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roc	om davs) through December	31 of the cost	0	5
	reporting period				
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December (31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	374	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	onlv (including private m	room davs)	0	10
	through December 31 of the cost reporting period (see instruc	ctions)	5 1		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
. 00 . 00	Total nursery days (title V or XIX only)	alli (exci uuriig swiriig-beu	uays)	2, 031	
	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ac after December 21 of	the cost	0.00	10
. 00	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	าร)		18, 342, 064	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	na period (line 6	0	23
00	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		18, 342, 064	27
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	pue line 22) (coo instru	stions)	0.00	
. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	18, 342, 064	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
	Adjusted general inpatient routine service cost per diem (see			1,078.82	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			403, 479 0	
	Total Program general inpatient routine service cost (line 39	, , ,		0	1 40

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	MARION GENERA	Provider CO	CN: 15-0011	Period: From 07/01/2017	u of Form CMS- Worksheet D-1		
					To 06/30/2018			
			Titl	e XIX	Hospi tal	11/26/2018 2: Cost	38 p	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
. 00	NURSERY (title V & XIX only)	1, 664, 750	2, 031	819. (57 0	C) 42	
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	5, 471, 065	3, 638	1, 503. 8	37 0	C	43	
. 00	CORONARY CARE UNIT	0, 1, 1, 000	0,000	.,			44	
. 00	BURN INTENSIVE CARE UNIT						45	
. 00	SURGICAL INTENSIVE CARE UNIT						46	
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47	
						1.00		
. 00	Program inpatient ancillary service cost (Wks			nc)		300, 583		
. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(:	see instructio	115)		704, 062	2 49	
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sur	n of Parts I and	C	50	
. 00	Pass through costs applicable to Program inpa	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	C	51	
2.00	and IV) Total Program excludable cost (sum of lines {	50 and 51)				C	52	
3.00	Total Program inpatient operating cost exclude		lated, non-phy	sician anestł	netist, and	C		
	medical education costs (line 49 minus line 5	52)					-	
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					c	54	
. 00	Target amount per discharge					0.00		
. 00	Target amount (line 54 x line 55)					C		
. 00	Difference between adjusted inpatient operati	ing cost and tai	rget amount (I	ine 56 minus	line 53)	C		
3.00 9.00	Bonus payment (see instructions)	porting period (anding 1006 u	ndated and co	mounded by the	0.00		
. 00	00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
0. 00	Lesser of lines 53/54 or 55 from prior year of					0.00		
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C) 61	
	amount (line 56), otherwise enter zero (see i		s (THES 54 X	60), 01 1% 01	the target			
2. 00	Relief payment (see instructions)					C		
8. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			C	0 63	
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decer	mber 31 of the	cost reporti	ng period (See	C	64	
	instructions)(title XVIII only)	Ū			0 1 1			
6.00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the c	ost reportino	g period (See	C) 65	
5.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line (64 plus line 6	5)(title XVII	l only). For	C	66	
	CAH (see instructions)				•			
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	eporting period	C	67	
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	ortina period	0	68	
	(line 13 x line 20)					_		
9.00	Total title V or XIX swing-bed NF inpatient i PART III - SKILLED NURSING FACILITY, OTHER NU					C) 69	
). 00	Skilled nursing facility/other nursing facili				1		70	
. 00	Adjusted general inpatient routine service co	2					71	
. 00	Program routine service cost (line 9 x line)			25)			72	
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 35)			73	
. 00	Capital -related cost allocated to inpatient	•		orksheet B, F	Part II, column		75	
	26, line 45)		-					
. 00	Per diem capital related costs (line 75 ÷ lin Program capital related costs (line 9 × line						76	
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						78	
. 00	Aggregate charges to beneficiaries for excess		rovider record	s)			79	
. 00	Total Program routine service costs for compa	arison to the co			nus line 79)		80	
. 00	Inpatient routine service cost per diem limit		\ \				81	
. 00 . 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82	
. 00	Program inpatient ancillary services (see ins		-,				84	
5.00	Utilization review - physician compensation		ns)				85	
. 00	Total Program inpatient operating costs (sum		rough 85)				86	
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					2, 980	87	
	Adjusted general inpatient routine cost per o		line 2)			1, 078. 82		
3.00								

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1		
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:		
		Titl	e 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, 877, 195	18, 342, 064	0. 15686	3 3, 214, 884	504, 296	90.00	
91.00 Nursing School cost	0	18, 342, 064	0.00000	0 3, 214, 884	0	91.00	
92.00 Allied health cost	0	18, 342, 064	0.00000	0 3, 214, 884	0	92.00	
93.00 All other Medical Education	0	18, 342, 064	0.00000			93.00	

	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST MARION GENERAL	Provider CCN: 15-0011	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T011	From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2::	
		Title XIX	Subprovider - IRF	Cost	<u>oo pii</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		l		
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs oveluding nowhern)		2, 681	1.
. 00	Inpatient days (including private room days, excluding swing-			2, 681	2.
00	Private room days (excluding swing-bed and observation bed da do not complete this line.		ivate room days,	0	3.
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	2, 681 0	4. 5.
00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	31 of the cost	0	7.
. 00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	swing-bed and	16	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		oom days)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e	only (including private r	room days) after	0	11.
2. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		e room days)	0	12.
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)			0 2, 031	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ing period (line	3, 631, 404 0	21 22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3, 631, 404	26 27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and observation had at	argos)		1 20
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	eu anu observation bed Cr	iai yes <i>i</i>	0	
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi		tions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	0 3, 631, 404	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			
3. 00	Adjusted general inpatient routine service cost per diem (see			1, 354. 50	
8. 00 9. 00		e 38)		1, 354. 50 21, 672 0	

	Financial Systems ATION OF INPATIENT OPERATING COST	MARION GENERAL	HOSPI TAL Provi der C	CN: 15-0011	In Lie Period:	eu of Form CMS- Worksheet D-	
				CCN: 15-T011	From 07/01/2017 To 06/30/2018	Date/Time Pre	epare
			Titl	e XIX	Subprovider -	11/26/2018 2: Cost	:38 p
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient CostIn		col . 2)		(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00 C	3.00	4.00 00 0	5.00) 42
	Intensive Care Type Inpatient Hospital Units		-	1			
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	C	0.	00 C		43
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Lino 200)			1.00 5,955	5 48
. 00	Total Program inpatient costs (sum of lines			ns)		27, 627	
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine se	rvices (from	Wkst. D, su	m of Parts I and	(50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II		51
. 00	and IV)	50 and 51)					52
2.00 3.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital rela	ted, non-phy	sician anest	hetist, and	(
. 00	Program di scharges						54
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targ	et amount (I	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	0 0			ŗ	0	58
. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period en	ding 1996, ι	pdated and c	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ted by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that are the state of t	n expected costs				() 61
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	i ons)			(63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	cost report	ing period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reporting	g period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	nlus line A	5)(title XVI	ll only) For		66
	CAH (see instructions)				5,		
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	Ū					
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 of	the cost rep	orting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N) 69
. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID routi	ne service d	ost (line 37)		70
. 00 . 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		e 70 ÷ line	2)			71
. 00	Medically necessary private room cost applic		line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	•			Dest II eelume		74
. 00	Capital-related cost allocated to inpatient 26, line 45)		USIS (IFOM V	IULKSHEEL B, I	Fait II, COLUMN		75
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces	• •					79
. 00 . 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		t limitation	ı (ııne /8 min	nus line 79)		80
. 00	Inpatient routine service cost per dreim rimi						82
. 00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation)				84
. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions					(0 87
	Adjusted general inpatient routine cost per		ine 2)			0.00	
	Observation bed cost (line 87 x line 88) (se	- !				1 6) 89

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2017	Worksheet D-1	
		Component (To 06/30/2018		
		Titl	e XIX	Subprovider -	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	602, 601	3, 631, 404	0. 16594	2 0	0	90.00
91.00 Nursing School cost	0	3, 631, 404	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 631, 404	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 631, 404	0. 00000	0 0	0	93.00

Health Financial Systems MARION GENERAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN. 1E 0011		eu of Form CMS-	
INPATIENT ANCILLARY SERVICE CUST APPORTIONMENT	Provider C	CN: 15-0011	Period: From 07/01/2017	Worksheet D-3	i
			To 06/30/2018		nared.
				11/26/2018 2:	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			9, 043, 392		30.0
31. 00 03100 I NTENSI VE CARE UNI T			2, 574, 720		31.0
40. 00 04000 SUBPROVIDER - IPF			C		40.0
41. 00 04100 SUBPROVIDER - IRF			C		41.0
42. 00 04200 SUBPROVI DER			C		42.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1738	42 12, 481, 967	2, 169, 890	50.0
51.00 05100 RECOVERY ROOM		0.0000	00 0	0 0	51.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2733	47 1, 028, 087	281, 024	54.0
57.00 05700 CT SCAN		0. 0477	18 2, 523, 608	120, 422	57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2542	.06 140, 701	35, 767	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3375	42 1, 413, 655	477, 168	59.0
60. 00 06000 LABORATORY		0.6642	40 1, 984, 350	1, 318, 085	60.0
60. 01 06001 ONCOLOGY		0. 3221			
60. 02 06002 RADIATION ONCOLOGY		0.0000	00 0	0	60.0
65. 00 06500 RESPI RATORY THERAPY		0. 4173		566, 605	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 2956			
69. 00 06900 ELECTROCARDI OLOGY		0. 2021			
69. 01 06901 CARDI AC REHAB		0. 5908			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0 0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1874		-	
OUTPATIENT SERVICE COST CENTERS		0.1874	4, 117, 003	0 771,073	13.0
90. 00 09000 CLINIC		1. 1085	99 0	0	90.0
91. 00 09100 EMERGENCY		0. 1392			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5025			
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)		0. 0000			
OTHER REIMBURSABLE COST CENTERS		0.0000		ν <u>ι</u> 0	72.0
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			33, 411, 716	7, 208, 836	
201.00 Less PBP Clinic Laboratory Services-Program only charge	nes (line 61)		00, 411, 710	, 200, 000	201.0
202.00 Net charges (line 200 minus line 201)			33, 411, 716	()	201.0
zuz. ou liner charges (The zuu minus the zur)		1	33, 411, /10	4	1202. U

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0011 Component CON: 15-0011 To 0b/30/2018 Provider CCN: 15-0011 To 0b/30/2018 Worksheet D-3 Date/Time Propared: 11/2/2018 2:38 pm Impatient Program Cost Center Description Title XVIII Subprovider CON: 15-0011 To Charges Worksheet D-3 Date/Time Propared: 10/2/2018 2:38 pm Impatient Program Cost Center Description Ratio of Cost To Charges Impatient Program Costs Cost Center Description Provider CON: 15-0011 To Charges Provider CON: 15-0011 To Date/Time Program Costs Cost Center Description Impatient Program Costs Cost Center Description 0 30.00 30.00 0.00 03000 (INTENSIVE CARE UNIT 0.00 0 0 30.00 1.00 2.00 2.760.498 41.00 0.00 04000 Supprovider Cost Centers 0 42.00 0.00 04000 Supprovider Cost Centers 0.073842 62.184 10.800 0.00 05000 OPERATING ROOM AMCILLARY SERVICE COST CENTERS 0.000000 0 0.511.00 50.00 05600 MAGNETIC RESONANCE I MAGING (MRI) 0.273347 37.551 10.267 50.00 05600 MAGNETIC RESONANCE I MAGING (MRI) 0.254206 159.993	Heal th	Financial Systems	MARION GENERAL HOSPIT	AL		In Lie	u of Form CMS-	2552-10
Component CCN: 15-T011 To 06/30/2015 Date/Time Prepared: 11/20/2018.238.pm Title XVIII Subprovider - To Charges PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Cost Center Description 1.00 2.00 3.00 30.00 40.00	I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi	der C	CN: 15-0011		Worksheet D-3	;
Impatient Impatient Impatient Impatient Program Costs (col. 1 x col. 2) 0.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 3.00 11.00 2.00 3.00 3.00 31.00 03000 ADULTS & PEDIATRICS 0 3.00 32.000 03100 INTENSIVE CARE UNIT 0 3.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 0.00 0 0 43.00 50.00 05000 OPERATING ROOM 0.173842 62.184 10.810 50.00 51.00 05100 OPECOVERY ROOM 0.000000 0 0 51.00 52.00 05000 OPERATING ROOM 0.273347 37.561 10.267 54.00 58.00 05000 MARTH CRESONARCE IMAGING (MRI) 0.337542 4.666 58.00 59.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
Title XVIII Subprovider - IRF PPS Cost Center Description Ratio of Cost To Charges Inpatient To Charges Inpatient Program Costs Col 1 x col. 2) Inpatient Program Costs Col 1 x col. 2) Inpatient Program Costs Col 1 x col. 2) 30:00 03000 ADULTS & PEDIATRICS 31:00 0 30:00 30:00 30:00 40:00 G4000 SUBBROVIDER - IPF 0 0 31:00 30:00 41:00 G4200 SUBBROVIDER - IPF 0 0 41:00 42:00 G4200 SUBBROVIDER - IFF 2, 760, 498 41:00 43:00 G5000 OPERATING ROOM 0.173842 62, 184 10, 810 50:00 G5000 OPERATING ROOM 0.000000 0 0 0 51:00 51:00 D5100 RECOVERY ROOM 0.000000 0 0 0 51:00 54:00 D5400 RADIOLOGY-DIAGNOSTIC 0.273347 37.561 10.267 54:00 59:00 D5500 MARETIC RESONANCE IMAGING (MRI) 0.3542/td> 4.666 58:00 59:00 59:00 59:00 59:00 59:00 59:00 59:00 69:00 69:00 69:00 69:00 69:00 69:00 <			Compo	onent (CCN: 15-1011	10 06/30/2018		
Cost Center Description Inpatient To Charges Inpatient Program Charges Inpatient Program (col. 1 x col. 2.00 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 31.00 0.00 30.00 31.00 03100 INTENSI & CARE UNIT 0 0.00 31.00 40.00 SUBPROVIDER - IPF 0 0 31.00 43.00 04000 SUBPROVIDER - IPF 2.760.498 41.00 43.00 04000 OPERATINE ROM 0.173842 62.184 10.810 50.00 05000 OPERATINE ROM 0.173842 62.184 10.810 55.00 51.00 05100 RECOVERY ROM 0.04000 RADILCOVERY ROM 0.04000 RADILCOVERY ROM 0.0407178 50.131 2.410 57.00 52.00 05000 CARDIAC CATHETERIZATION 0.337542 4.686 1.582 59.00 60.00 060001 MACCERY 0.000000 0 0.00000 0 60.02 65.00 060000 RESPI RATION 0.337542 4.686 1.582 59.00 60.00 060001 RESPI RATION				Ti +1 o	XVIII	Subprovidor		38 pili
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Inpatient Col 1 x col. 2) 30:00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31:00 03000 ADULTS & PEDIATRICS 0 31:00 31:00 31:00 04000 SUBPROVIDER - IPF 0 0 31:00 31:00 41:00 04200 SUBPROVIDER - IFF 2.760.498 41:00 42:00 42:00 42:00 04200 SUBPROVIDER - IFF 0 0 31:00 31:00 50:00 05000 PECOVERY ROOM 0.000000 0 0 42:00 51:00 05000 RECOVERY ROOM 0.0000000 0 0 51:00 51:00 05000 CARDIAC CATHETER XATION 0.337542 4:666 1:59:93 4:066 58:00 050800 MAGNETIC RESONANCE I MAGING (MRI) 0.254206 15:993 4:066 58:00 60:00 060000 LABORATORY THERAPY 0.337542 4:666 1:58:25 59:00 60:00 060000 RESPIRATINGED TO PATIENTS 0.300000				nue	XVIII		PP3	
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40.00 04000 SUBPROVI DER - 1 PF 0 40.00 41.00 04100 SUBPROVI DER - 1 RF 2, 760, 498 41.00 42.00 04200 SUBPROVI DER - 1 RF 2, 760, 498 42.00 43.00 04200 SUBPROVI DER - 1 RF 42.00 43.00 ANCILLARY SERVICE COST CENTERS 0 0 50.00 0 0 51.00 52.00 55.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 <	30.00	03000 ADULTS & PEDIATRICS				0		30.00
40.00 04000 SUBPROVI DER - 1 PF 0 40.00 41.00 04100 SUBPROVI DER - 1 RF 2, 760, 498 41.00 42.00 04200 SUBPROVI DER - 1 RF 2, 760, 498 42.00 43.00 04200 SUBPROVI DER - 1 RF 42.00 43.00 ANCILLARY SERVICE COST CENTERS 0 0 50.00 0 0 51.00 52.00 55.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 <	31.00	03100 INTENSIVE CARE UNIT				0		31.00
42.00 04200 SUBPROVI DER 0 42.00 43.00 04300 NURSERY 0 43.00 AMCI LLARY SERVI CE COST CENTERS 0 0.173842 62.184 10.810 50.00 50.00 05400 RADI OLGY-DI AGNOSTI C 0.273347 37,561 10.267 54.00 51.00 05400 RADI OLGY-DI AGNOSTI C 0.233347 37,561 10.267 54.00 55.00 05500 CARDI AC CATHETERI ZATI ON 0.337542 4,686 1,582 59.00 60.00 06000 LABORATORY 0.64240 72,626 48,241 60.01 60.01 0K0001 OKOLOCOY 0.322103 532 1711 60.02 60.00 RADI ATI ON ONCOLOGY 0.322103 532 1741 60.01 60.02 RADI ATI ON ONCOLOGY 0.295647 2.127,900 64.00 64.00 60.00 RADI ATI ON ONCOLOGY 0.322103 532 1711 60.01 66.00 64.00 64.00 64.02 62.9107 66.00 69.01 66.00 66.00 66.00 66						0		40.00
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57.00 05700 CT SCAN 0.047718 50,513 2,410 57.00 58.00 05800 MACNETIC RESONANCE I MAGI NG (MRI) 0.254206 15,993 4,066 58.00 59.00 05800 CARDI AC CATHETERI ZATI ON 0.337542 4,686 1,582 59.00 60.01 06001 DABORATORY 0.664240 72,626 48,241 60.00 60.02 RADI ATI ON ONCOLOGY 0.322103 532 171 60.01 60.02 RADI ATI ON ONCOLOGY 0.417355 99.295 41,441 65.00 65.00 06500 RESPI RATORY THERAPY 0.295647 2,127,900 629,107 66.00 66.00 06901 CARDI AC REHAB 0.590870 0 0 07100 69.01 71.00 OT300 DRUE CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 71.00 73.00 07300 DRUES CHARGED TO PATIENTS 0.187450 357,172 66,92 73.00 70.00 DEVEX CHARGED TO PATIENTS 0.187450 357,172 69,92 73.00 70.00 <t< td=""><td>54.00</td><td>05400 RADI OLOGY-DI AGNOSTI C</td><td></td><td></td><td>0. 2733</td><td>47 37, 561</td><td>10, 267</td><td>54.00</td></t<>	54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 2733	47 37, 561	10, 267	54.00
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.254206 15,993 4,066 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.337542 4,686 1,582 59.00 60.00 LABORATORY 0.664240 72,626 48,241 60.01 60.01 0KOLOGY 0.322103 532 111 60.01 60.02 A6002 RADIATI ON ONCOLOGY 0.000000 0 60.02 65.00 06500 RESPI RATORY THERAPY 0.417355 99.295 41,441 65.00 65.00 06600 HYSI CAL THERAPY 0.295647 2,127,900 629,107 66.00 64.00 06900 ELECTROCARDI OLOGY 0.202192 55,204 11,162 69.00 69.01 06900 CAL STREMARE TO PATI ENTS 0.000000 0 0 71.00 71.00 MPL DEV. CHARGED TO PATI ENTS 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.187450 357,172 66,952 73.00 90.00 09000 CLI NI C 1.108599								
59.00 05900 CARDI AC CATHETERI ZATI ON 0.337542 4,686 1,582 59.00 60.00 06000 LABORATORY 0.664240 72,626 48,241 60.00 60.01 0K001 ONCOLOGY 0.322103 532 171 60.01 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 0 0 60.02 65.00 06500 RESPI RATORY THERAPY 0.417355 99,295 41,441 65.00 66.00 06600 PHYSI CAL THERAPY 0.295647 2,127,900 629,107 66.00 69.01 06900 ELECTROCARDI OLOGY 0.202192 55,204 11,162 69.00 69.01 06901 CARDI AC REHAB 0.590870 0 0 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 71.00 73.00 07300 PRUGS CHARGED TO PATI ENTS 0.187450 357.172 66.952 90.00 09000 CLINI C 1.108599 0 0 90.00 91.00 09100 EMERGENCY <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
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60.01 06001 0NC0L0GY 0.322103 532 171 60.01 60.02 06002 RADIATION ONCOLOGY 0.000000 0 0 60.02 65.00 06500 RESPIRATORY THERAPY 0.417355 99, 295 41, 441 65.00 66.00 06600 PHYSICAL THERAPY 0.295647 2, 127, 900 629, 107 66.00 69.00 06900 ELECTROCARDIOLOGY 0.202192 55, 204 11, 162 69.00 69.01 06901 CARDIAC REHAB 0.590870 0 0 69.01 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 357, 172 66, 952 90.00 090000 CLINIC 0 90.00 90.00 90.00 90.00 91.00 09100 EMERGENCY 0.187450 357, 172 66, 952 73.00 92.00 09200 OBSERVATI ON BEDS (DI STI								•
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65.00 06500 RESPI RATORY THERAPY 0.417355 99,295 41,441 65.00 66.00 06600 PHYSI CAL THERAPY 0.295647 2,127,900 629,107 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 55,204 11,162 69.00 69.01 06901 CARDI AC REHAB 0.17100 0.000000 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.0000000 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 357,172 66,952 73.00 00100 EMERGENCY 0.139237 71,113 9,002 90.00 90.00 92.00 92.01 92.01 92.00 92.01 92.00 92.01 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>								•
66.00 06600 PHYSI CAL THERAPY 0.295647 2,127,900 629,107 66.00 69.00 06900 ELECTROCARDI OLOGY 0.202192 55,204 11,162 69.00 69.01 06901 CARDI AC REHAB 0.590870 0 0 69.01 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.187450 357,172 66,92 73.00 00000 CLINIC 1.108599 0 0 90.00 90.00 91.00 92.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>41, 441</td> <td></td>							41, 441	
69.00 06900 ELECTROCARDI OLOGY 0.202192 55, 204 11, 162 69.00 69.01 06901 CARDI AC REHAB 0.590870 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.187450 357,172 66,927 73.00 00TPATI ENT SERVICE COST CENTERS 0 0.187450 357,172 66,920 90.00 90.00 09000 CLINIC 1.108599 0 0 90.00 91.00 09100 EMERGENCY 0.139237 71,113 9,902 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.502521 0 0 92.00 92.01 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 0 92.01 00102 OTHER REI MBURSABLE COST CENTERS 0 0.000000 0 92.01 002000 OPS000 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
69.01 06901 CARDI AC REHAB 0.590870 0 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 357.172 66.952 0UTPATIENT SERVICE COST CENTERS 0 0.187450 357.172 66.952 70.00 90.00 09000 CLINIC 1.108599 0 0 90.00 91.00 09100 EMERGENCY 0.139237 71.113 9.902 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.502521 0 0 92.00 92.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 92.00 92.01 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 92.01 020100 DSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 0 92.01 020100 OPSO00 AMBULANCE SERVI CES 2,954,779 836,111 <								
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 357,172 66,952 73.00 00 09000 CLINIC 1.108599 0 0 90.00 90.00 09100 EMERGENCY 0.139237 71,113 9,902 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.502521 0 0 92.01 92.01 092010 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 92.01 07HER REI MBURSABLE COST CENTERS 0.000000 0 0 92.01 07HER REI MBURSABLE COST CENTERS 95.00 0 95.00 0 95.00 0 95.00 0 95.00 2,954,779 836,111 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 20								
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 357,172 66,952 73.00 90.00 09000 CLINIC 1.108599 0 0 90.00 91.00 09100 EMERGENCY 0.139237 71,113 9,902 91.00 92.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.502521 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 92.01 07HER REIMBURSABLE COST CENTERS 0 0.000000 0 0 92.01 07HER REIMBURSABLE COST CENTERS 0 0 95.00 09500 AMBULANCE SERVI CES 95.00 200.00 Distribution of Lines 50 through 94 and 96 through 98) 2, 954, 779 836, 111 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00								•
73.00 07300 DRUGS CHARGED TO PATIENTS 0.187450 357,172 66,952 73.00 0UTPATIENT SERVICE COST CENTERS 0 09000 CLINIC 1.108599 0 0 90.00 90.00 09000 CLINIC 1.108599 0 0 90.00 91.00 09200 DBERVATION BEDS (NON-DISTINCT PART) 0.139237 71,113 9,902 91.00 92.00 09200 DBSERVATION BEDS (DISTINCT PART) 0.502521 0 0 92.00 92.01 09201 DBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 92.01 07HER REI MBURSABLE COST CENTERS 0 0 0 92.01 95.00 09500 AMBULANCE SERVICES 95.00 2,954,779 836,111 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00							-	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 1.108599 0 090.00 91.00 09100 EMERGENCY 0.139237 71,113 9,902 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.502521 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 92.01 07HER REI MBURSABLE COST CENTERS 0 0 0 92.01 95.00 09500 AMBULANCE SERVICES 95.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 20.954, 779 836, 111 200.00 201.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
90.00 09000 CLINIC 1.108599 0 0 90.00 91.00 09100 EMERGENCY 0.139237 71,113 9,902 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.502521 0 0 92.00 92.01 0BSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 92.01 0THER REI MBURSABLE COST CENTERS 0 0 92.01 95.00 95.00 90.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 20.00 201.00	10100				011071	001/112	00,702	10100
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.502521 0 0 92. 00 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 0 0 92. 01 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 92. 00 92. 01 95. 00 09500 AMBULANCE SERVICES 95. 00 2, 954, 779 836, 111 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201. 00	90.00				1. 1085	99 0	C	90.00
92. 00 92. 01 09201 0BSERVATION BEDS (NON-DISTINCT PART) 0.502521 0.000000 0 92. 00 92. 01 92. 01 0THER REIMBURSABLE COST CENTERS 0.502521 0.00000 0 0 92. 01 95. 00 200. 00 201. 00 09500 Less PBP Clinic Laboratory Services-Program only charges (line 61) 2, 954, 779 0 836, 111 200. 00 201. 00 95. 00 201. 00	91.00	09100 EMERGENCY			0. 1392	37 71, 113	9, 902	91.00
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 0 92. 01 0THER REI MBURSABLE COST CENTERS 0.000000 92. 01 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 2, 954, 779 836, 111 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 5025			92.00
OTHER REI MBURSABLE COST CENTERS95. 0009500AMBULANCE SERVICES200. 00Total (sum of lines 50 through 94 and 96 through 98)2, 954, 779836, 111201. 00Less PBP Clinic Laboratory Services-Program only charges (line 61)0201. 00					0.0000	0 00	C	92.01
200.00 Total (sum of lines 50 through 94 and 96 through 98) 2,954,779 836,111 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							-	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95.00	09500 AMBULANCE SERVI CES						95.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	200.00	Total (sum of lines 50 through 94 and 9	96 through 98)			2, 954, 779	836, 111	200.00
202.00 Net charges (line 200 minus line 201) 2,954,779 202.00	201.00	Less PBP Clinic Laboratory Services-Pro	ogram only charges (line	e 61)		0		201.00
	202.00			-		2, 954, 779		202.00

	ENERAL HOSPI TAL			eu of Form CMS-	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0011	Peri od:	Worksheet D-3	5
			From 07/01/2017 To 06/30/2018	Date/Time Pre	norod
			10 00/30/2016	11/26/2018 2:	
	Ti tl	e XIX	Hospi tal	Cost	<u>00 piii</u>
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			Ŭ	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			505, 156		30.00
31. 00 03100 I NTENSI VE CARE UNI T			173, 586		31.00
10. 00 04000 SUBPROVI DER – I PF			0		40.00
11.00 04100 SUBPROVIDER – IRF			0		41.00
12. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS				1	
50. 00 05000 OPERATI NG ROOM		0. 1738			
51.00 05100 RECOVERY ROOM		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2733		13, 130	54.00
57.00 05700 CT SCAN		0.0477	18 74, 400	3, 550	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2542	06 3, 998	1, 016	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3375	42 44, 099	14, 885	59.00
50. 00 06000 LABORATORY		0. 6642	40 80, 000	53, 139	60.00
50. 01 06001 ONCOLOGY		0. 3221		305	60. 0 ⁴
50. 02 06002 RADIATION ONCOLOGY		0.0000	00 0	0	60.02
55. 00 06500 RESPI RATORY THERAPY		0. 4173	55 61, 859	25, 817	65.00
56. 00 06600 PHYSI CAL THERAPY		0. 2956	47 19, 443	5, 748	66.00
59. 00 06900 ELECTROCARDI OLOGY		0. 2021	92 46, 729	9, 448	69.00
59. 01 06901 CARDI AC REHAB		0. 5908		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1874		-	
OUTPATIENT SERVICE COST CENTERS					1
20. 00 09000 CLINIC		1. 1085	99 0	0	90.00
91. 00 09100 EMERGENCY		0. 1392		32, 675	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5025			
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000		-	
OTHER REIMBURSABLE COST CENTERS		0.0000			1
25. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through	98)		1, 411, 238	300, 583	
201.00 Less PBP Clinic Laboratory Services-Program only			0		201.00
202.00 Net charges (line 200 minus line 201)	J== (01)	1	1, 411, 238	1	202.00

Health Financial Systems	MARION GENERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (CCN: 15-0011	Period:	Worksheet D-3	3
	Component	CCN: 15-T011	From 07/01/2017 To 06/30/2018	Date/Time Pre	narod
	component	CON. 13-1011	10 00/ 30/ 2010	11/26/2018 2:	
	Tit	le XIX	Subprovider -	Cost	
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	<u>2)</u> 3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30,00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			21, 072		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM		0. 1738	42 0	C	50.00
51.00 05100 RECOVERY ROOM		0.0000	0 00	C	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2733	47 307	84	54.00
57.00 05700 CT SCAN		0.0477	18 0	C	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2542	0 0	C	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3375	42 0	C	59.00
60. 00 06000 LABORATORY		0.6642	40 403	268	60.00
60. 01 06001 ONCOLOGY		0. 3221	03 0	C	60. 01
60. 02 06002 RADIATION ONCOLOGY		0.0000		C	
65. 00 06500 RESPI RATORY THERAPY		0. 4173			1
66. 00 06600 PHYSI CAL THERAPY		0. 2956		4, 614	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2021		C	
69. 01 06901 CARDI AC REHAB		0. 5908		C	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		C	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		C	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1874	50 3, 575	670	73.00
OUTPATIENT SERVICE COST CENTERS		1 1005			
90. 00 09000 CLINIC		1.1085			
91.00 09100 EMERGENCY		0. 1392		C	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0.5025		-	
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0.0000	0 00	C	92.01
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and	96 through 98)		20, 654	5 055	200.00
201.00 Less PBP Clinic Laboratory Services-P			20, 034	5,955	200.00
202.00 Net charges (line 200 minus line 201)			20, 654		201.00
202.00 met charges (Trite 200 millas Trite 201)		I	20,034	l	1202.00

1.00 DRG A 1.01 DRG a 1.02 DRG a 1.03 DRG f 1.03 DRG f 1.04 DRG f 0.04 DRG f 1.03 DRG f 1.04 DRG f 0.04 DRG f 2.00 Outli 2.01 Outli 2.02 Outli 3.00 Manag 4.00 Bed d 5.00 FTE c 6.00 FTE c 7.01 ACA S 7.01 ACA S 7.01 ACA S 7.02 The a under repor 8.01 The a under FE c 9.00 Sum o 11.00 FTE c 12.00 Curre 13.00 Total 14.00 Curre 15.00 Sum o 16.00 Adj us 17.00 Adj us </th <th>iated programs in accordance with 42 CFR 413.75(b), 413.</th> <th>ring on or after October for discharges occurring for discharges occurring tions) orting period (see instru- st recent cost reporting the criteria for an add- under 42 CFR §412.105(f) r 42 CFR §412.105(f)(1)(i athic and osteopathic pro</th> <th>1 (see pri or to October on or after ucti ons) peri od endi ng on on to the cap</th> <th>11/26/2018 2: 3 PPS 1.00 0 3, 363, 475 10, 842, 099 0 0 167, 898 0 0 0 90. 84 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</th> <th>1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 3. 00 4. 00 5. 00</th>	iated programs in accordance with 42 CFR 413.75(b), 413.	ring on or after October for discharges occurring for discharges occurring tions) orting period (see instru- st recent cost reporting the criteria for an add- under 42 CFR §412.105(f) r 42 CFR §412.105(f)(1)(i athic and osteopathic pro	1 (see pri or to October on or after ucti ons) peri od endi ng on on to the cap	11/26/2018 2: 3 PPS 1.00 0 3, 363, 475 10, 842, 099 0 0 167, 898 0 0 0 90. 84 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 3. 00 4. 00 5. 00		
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8.02 The a under under 9.00 Sum o instr 10.00 FTE c 11.00 FTE c 12.00 Curre 13.00 Total 14.00 Adj us 15.00 Sum o 16.00 Adj us 17.00 Adj us 19.00 Curre 21.00 Enter 22.01 IME p Indira Call from the p 23.00 Iff (1) 24.00 If th 25.00 If th	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.						
9.00 Sum of instr 10.00 FTE c 11.00 FTE c 12.00 Curre 13.00 Total other other 15.00 Sum o 16.00 Adj us 17.00 Adj us 18.00 Adj us 12.00 Enter 22.00 IME p 22.01 IME p Indira Carre 23.00 IME f 25.00 If th							
10.00 FTE c 11.00 FTE c 12.00 Curre 13.00 Total 0 other 14.00 Sum o 15.00 Sum o 16.00 Adj us 17.00 Adj us 18.00 Adj us 19.00 Curre 20.00 Prior 21.00 Enter 22.01 IME p Indire (f) (1) 23.00 IME f 25.00 If th	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)						
12.00 Curre 13.00 Total 14.00 Total other other 15.00 Sum o 16.00 Adj us 17.00 Adj us 18.00 Adj us 19.00 Curre 20.00 Prior 21.00 Enter 22.01 IME p Indira (f)(1 23.00 IME f 25.00 If th	count for allopathic and osteopathic programs in the curr	rent year from your recom	rds				
13.00 Total 14.00 Total other other 15.00 Sum o 16.00 Adj us 17.00 Adj us 18.00 Adj us 19.00 Curre 20.00 Prior 22.00 IME p 22.01 IME p 1ndira (f) (1 24.00 IME F 25.00 If th	count for residents in dental and podiatric programs. ent year allowable FTE (see instructions)			0.00	11.00 12.00		
other 15.00 Sum o 16.00 Adjus 17.00 Adjus 18.00 Adjus 19.00 Curre 20.00 Prior 21.00 Enter 22.00 IME p 1ndire 23.00 Numbe (f)(1 24.00 IME F 25.00 If th instr	allowable FTE count for the prior year.			0.00			
15.00 Sum o 16.00 Adj us 17.00 Adj us 18.00 Adj us 19.00 Curre 20.00 Prior 21.00 Enter 22.00 IME p Indira 23.00 Xumbe (f) (1 24.00 IME F 25.00 If th	allowable FTE count for the penultimate year if that year wise enter zero.	ear ended on or after Sep	otember 30, 1997,	0.00	14.00		
17.00 Adjus 18.00 Adjus 19.00 Curre 20.00 Prior 21.00 Enter 22.00 IME p 22.01 IME p 23.00 Number (f)(1 1ME f 25.00 If th	of lines 12 through 14 divided by 3.				15.00		
18.00 Adjus 19.00 Curre 20.00 Prior 21.00 Enter 22.01 IME p Indira Indira 23.00 IME F 24.00 IME F 25.00 If th instr Instr	stment for residents in initial years of the program				16.00		
19.00 Curre 20.00 Prior 21.00 Enter 22.01 IME p Indire Indire 23.00 Numbe 24.00 IME f 25.00 IME f 19.00 IME f 19.00 IME f	stment for residents displaced by program or hospital clo sted rolling average FTE count	osure			17.00 18.00		
20.00 Prior 21.00 Enter 22.00 IME p 22.01 IME p Indire 23.00 Numbe (f)(1 24.00 IME F 25.00 If th instr	ent year resident to bed ratio (line 18 divided by line -	4).		0. 000000			
22.00 IME p 22.01 IME p Indira 23.00 Numbe (f)(1 24.00 IME F 25.00 If th instr	year resident to bed ratio (see instructions)			0.00000			
22.01 IME p Indire 23.00 Numbe (f)(1 24.00 IME F 25.00 If th instr	the lesser of lines 19 or 20 (see instructions)			0. 000000			
Indire 23.00 Numbe (f)(1 24.00 IME F 25.00 If th	payment adjustment (see instructions)						
(f)(1 24.00 IME F 25.00 If th instr	payment adjustment - Managed Care (see instructions) rect Medical Education Adjustment for the Add-on for § 42	22 of the MMA		0	22. 01		
24.00 IME F 25.00 If th instr	er of additional allopathic and osteopathic IME FTE resid 1)(iv)(C).	dent cap slots under 42 (CFR 412.105	0.00	23.00		
instr	TE Resident Count Over Cap (see instructions)						
	ne amount on line 24 is greater than -O-, then enter the ructions)	lower of line 23 or line	e 24 (see	0.00	25.00		
	dent to bed ratio (divide line 25 by line 4)			0. 000000			
	payments adjustment factor. (see instructions)						
		c)		0	28.00 28.01		
	add-on adjustment amount (see instructions) add-on adjustment amount - Managed Care (see instruction	3)		0	29.00		
29.01 <u>Total</u>	add-on adjustment amount - Managed Care (see instruction			0	29.01		
	add-on adjustment amount - Managed Care (see instruction: IME payment (sum of lines 22 and 28) IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		5.37	30.00		
	add-on adjustment amount - Managed Care (see instruction: IME payment (sum of lines 22 and 28)	-	ctions)				
32.00 Sum o	add-on adjustment amount - Managed Care (see instructions IME payment (sum of lines 22 and 28) IME payment - Managed Care (sum of lines 22.01 and 28.0 roportionate Share Adjustment	-	ctions)	26.09	31.00		
33.00 Allow 34.00 Dispr	add-on adjustment amount - Managed Care (see instructions IME payment (sum of lines 22 and 28) IME payment - Managed Care (sum of lines 22.01 and 28.0 opportionate Share Adjustment entage of SSI recipient patient days to Medicare Part A p entage of Medicaid patient days (see instructions) of lines 30 and 31	patient days (see instruc	ctions)		32.00		

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prep 11/26/2018 2:3	
		Title XVIII	Hospi tal	PPS	50 piii
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		1		
5.00	Total uncompensated care amount (see instructions)		5, 977, 483, 147	6, 766, 695, 164	35.0
5. 01	Factor 3 (see instructions)		0. 000142355	0. 000205554	35.0
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter	r zero on this line) (s	ee 850, 925	1, 390, 922	35.0
	instructions)				
5.03	Pro rata share of the hospital uncompensated care payment amou		214, 480		
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		1, 254, 813		36. C
0 00	Additional payment for high percentage of ESRD beneficiary dis	U U U U U U U	<u> </u>		40.0
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding of 652, 682, 683, 684 and 685 (see instructions)	discharges for MS-DRGS	0		40. C
			Before 1/1	On/After 1/1	
			1.00	1.01	
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	33. 684 an 685. (see	0	0	41.0
	instructions)				
1. 01	Total ESRD Medicare covered and paid discharges excluding MS-E	DRGs 652, 682, 683, 68	4 0	0	41.0
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qualif	fy for adjustment)	0.00		42. C
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	2, 683, 684 an 685. (se	e 0		43. C
	instructions)				
4.00	Ratio of average length of stay to one week (line 43 divided k	by line 41 divided by 7	0. 000000		44. C
5.00	days) Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45. (
6.00	Total additional payment (line 45 times line 44 times line 41.		0.00	0.00	45.0
7.00	Subtotal (see instructions)		16, 167, 032		47. (
8.00	Hospital specific payments (to be completed by SCH and MDH, sm	mall rural bospitals	15, 603, 267		48.0
0.00	only. (see instructions)		10,000,20,		10.0
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructions))		16, 167, 032	49.0
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and)	1, 191, 056	50. C
1.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.0
2.00	Direct graduate medical education payment (from Wkst. E-4, lir	ne 49 see instructions)		0	52.0
3.00	Nursing and Allied Health Managed Care payment			0	53.0
4.00 4.01	Special add-on payments for new technologies Islet isolation add-on payment			0	54. (54. (
4.01 5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	2)		0	55.0
6.00	Cost of physicians' services in a teaching hospital (see intru			0	56.0
7.00	Routine service other pass through costs (from Wkst. D, Pt. II		through 35).	0	57.0
8.00	Ancillary service other pass through costs from Wkst. D, Pt. I			0	58.
9.00	Total (sum of amounts on lines 49 through 58)	. ,		17, 358, 088	59.
0.00	Primary payer payments			0	60. (
1. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		17, 358, 088	
2.00	Deductibles billed to program beneficiaries			1, 925, 168	
	Coinsurance billed to program beneficiaries			36, 401	
3.00	Allowable bad debts (see instructions)			201, 617	64.
4.00	Adjusted reimbursable bad debts (see instructions)			131, 051	65.
4.00 5.00		ructions)		85, 885	66.
4.00 5.00 6.00	Allowable bad debts for dual eligible beneficiaries (see instr			15, 527, 570	67. 68.
4.00 5.00 6.00 7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		· · · · · · · · · · · · · · · · · · ·		
4.00 5.00 6.00 7.00 8.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a		,	0	
4.00 5.00 6.00 7.00 8.00 9.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).		,	0	69.
4.00 5.00 6.00 7.00 8.00 9.00 0.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(For SCH see instruction	ns)	0	69. 70.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr	(For SCH see instruction	ns)	0 0 0	69. 70. 70.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration	(For SCH see instruction	ns)	0 0 0	69. 70. 70. 70.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	(For SCH see instruction ration) adjustment (see	ns)	0 0 0	69. 70. 70. 70. 70.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration	(For SCH see instruction ration) adjustment (see	ns)	0 0 0	69. 70. 70. 70. 70. 70.
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions)	(For SCH see instruction ration) adjustment (see	ns)	0 0 0 0	69. 70. 70. 70. 70. 70. 70.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88 0.89	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr	(For SCH see instruction ration) adjustment (see	ns)	0 0 0 0 0	69. 70. 70. 70. 70. 70. 70. 70. 70. 70. 70
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88 0.89 0.90 0.91	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	(For SCH see instruction ration) adjustment (see	ns)	0 0 0 0 0 0	69. 70. 70. 70. 70. 70. 70. 70. 70.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.50 0.87 0.88 0.89 0.90 0.91 0.92	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	(For SCH see instruction ration) adjustment (see	ns)	0 0 0 0 0 0	69. 70. 70. 70. 70. 70. 70. 70.

	Provider CC		Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Pre 11/26/2018 2:	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1.00	
.96 Low volume adjustment for federal fiscal year (yyyy) (Ente			0	0	70
 the corresponding federal year for the period prior to 10/ Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or 	rin column O		0	0	70
.98 Low Volume Payment-3				0	70
.99 HAC adjustment amount (see instructions)				132, 857	
.00 Amount due provider (line 67 minus lines 68 plus/minus lin	es 69 & 70)			15, 419, 872	
.01 Sequestration adjustment (see instructions)				308, 397	71
.02 Demonstration payment adjustment amount after sequestratio	n			0	
.00 Interim payments				15, 448, 495	72
.00 Tentative settlement (for contractor use only)				0	73
00 Balance due provider/program (line 71 minus lines 71.01, 7 73)				-337, 020	
.00 Protested amounts (nonallowable cost report items) in acco	rdance with			298, 692	75
CMS Pub. 15-2, chapter 1, §115.2					-
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	· · · · · · ·			0	1
.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see	instructions)			0	
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	
00 Operating outlier reconciliation adjustment amount (see in				0	
.00 Capital outlier reconciliation adjustment amount (see inst	,			0	
.00 The rate used to calculate the time value of money (see in				0.00	
.00 Time value of money for operating expenses (see instructio	· ·			0	
.00 Time value of money for capital related expenses (see inst	ructions)		Dut an ta 10/1	0	96
			Prior to 10/1 1.00	2.00	-
HSP Bonus Payment Amount			1.00	2.00	-
D. 00 HSP bonus amount (see instructions)			0	0	100
HVBP Adjustment for HSP Bonus Payment				0	1.00
1.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	1101
2.00 HVBP adjustment amount for HSP bonus payment (see instruct	ions)		0		102
HRR Adjustment for HSP Bonus Payment	1 0110)				1.02
3.00 HRR adjustment factor (see instructions)			0.0000	0.0000	1103
4.00 HRR adjustment amount for HSP bonus payment (see instructi	ons)		0		104
					-
Rural Community Hospital Demonstration Project (§410A Demo	nstration) Adjus	stment			
Rural Community Hospital Demonstration Project (§410A Demo 0.00 Is this the first year of the current 5-year demonstration					200
Rural Community Hospital Demonstration Project (§410A Demo 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.					200
0.00 Is this the first year of the current 5-year demonstration					200
0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.	period under t				
0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	period under t				201
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 	period under t				201 202
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 	period under tl line 49)	he 21st	nt 5-year demonst	ration	201 202
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 	period under tl line 49)	he 21st	nt 5-year demonst	ration	201 202
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 4.00 Medicare target amount 	period under tl line 49)	he 21st	nt 5-year demonst	rati on	201 202 203 204
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 	period under tl line 49)	he 21st	nt 5-year demonst	rati on	200 201 202 203 204 204
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 2 	period under ti line 49) in first year o	he 21st	nt 5-year demonst	ration	201 202 203 204 204
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 0.00 Case-mix adjustment factor (see instructions) 0.00 Case-mix adjustment factor (see instructions) 0.00 Medicare target amount Limitation (N/A period) 0.00 Medicare target amount 0.00 Case-mix adjusted target amount (line 203 times line 204) 0.00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement 	period under t line 49) in first year (05)	he 21st	nt 5-year demonst	rati on	201 202 203 204 205 206
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see i 	period under t line 49) in first year (05) nstructions)	he 21st	nt 5-year demonst		201 202 203 204 205 206 207
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the \$410A Demonstration (see i 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 	period under t line 49) in first year (05) nstructions)	he 21st	nt 5-year demonst		201 202 203 204 205 206 207 208
 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 100 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Medicare target amount 00 Medicare target amount 00 Case-mix adjusted target amount (line 203 times line 204) 00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement 00 Program reimbursement under the §410A Demonstration (see i 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 00 Adjustment to Medicare IPPS payments (see instructions) 	period under t line 49) in first year (05) nstructions)	he 21st	nt 5-year demonst		201 202 203 204 205 206 206 207 208 209
 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Medicare target amount 00 Medicare inpatient routine cost cap (line 202 times line 204) 00 Medicare inpatient routine cost cap (line 202 times line 204) 00 Medicare Part A Inpatient Reimbursement 00 Program reimbursement under the §410A Demonstration (see i 3.00 Medicare IPPS payments (see instructions) 00 Adjustment to Medicare IPPS payments (see instructions) 	period under t line 49) in first year o 05) nstructions) A, line 59)	he 21st	nt 5-year demonst		201 202 203 204 205 206 207 208 209 210
 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Medicare target amount 00 Medicare inpatient routine cost cap (line 202 times line 204) 00 Medicare inpatient routine cost cap (line 202 times line 204) 00 Medicare Part A Inpatient Reimbursement 00 Program reimbursement under the §410A Demonstration (see i 3.00 Medicare IPPS payments (see instructions) 00 Adjustment to Medicare IPPS payments (see instructions) 	period under t line 49) in first year o 05) nstructions) A, line 59)	he 21st	nt 5-year demonst		201 202 203 204 205 206 207 208 209 210
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 0.00 Case-mix adjustment factor (see instructions) 0.00 Case-mix adjustment factor (see instructions) 0.00 Medicare target amount 0.00 Medicare inpatient routine cost cap (line 203 times line 204) 0.00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 0.00 Medicare for future use 0.00 Comparision of PPS versus Cost Reimbursement 	period under t line 49) in first year (05) nstructions) A, line 59) ns)	he 21st	nt 5-year demonst		201 202 203 204 205 206 207 206 207 208 209 210
 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Case-mix adjustment factor (see instructions) 00 Medicare target amount 00 Medicare target amount 00 Case-mix adjusted target amount (line 203 times line 204) 00 Medicare inpatient routine cost cap (line 202 times line 204) 00 Medicare part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see i 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 00 Adjustment to Medicare IPPS payments (see instructions) 00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) 	period under t line 49) in first year (05) nstructions) A, line 59) ns)	he 21st	nt 5-year demonst		201 202 203 204
 0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 2 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see i 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instruction Comparision of PPS versus Cost Reimbursement 	period under t line 49) in first year (05) nstructions) A, line 59) ns)	he 21st	nt 5-year demonst		201 202 203 204 205 206 207 208 209 210 211

	Financial Systems		MARION GENERAL	Provider CC		Period:	u of Form CMS-2 Worksheet E	
						From 07/01/2017 To 06/30/2018	Part A Exhibi	pare
				Titlo	XVIII	Hospi tal	11/26/2018 2: PPS	38 p
		W/S F Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
. 00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.
. 01	payments DRG amounts other than outlier payments for discharges	1.01	3, 363, 475	0	3, 363, 47	5	3, 363, 475	1.
. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	10, 842, 099	0		10, 842, 099	10, 842, 099	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1. 03	0	0		0	0	1.
04	October 1 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after	1. 04	0	0		0	0	1.
00	October 1 Outlier payments for	2.00	167, 898	0	91, 29	3 76, 604	167, 897	2.
01	discharges (see instructions) Outlier payments for	2. 02	0	0		о о	0	2.
. 00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0		0 0	0	3.
. 00	Managed care simulated payments	3.00	0	0		0 0	0	4.
	Indirect Medical Education Adju		· · · · ·					
00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0 0.000000		5
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		o o	0	6
01	instructions) IME payment adjustment for managed care (see	22.01	0	0		o o	0	6
	instructions)							
~ ~	Indirect Medical Education Adju					0 0 00000		
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000	0 0. 000000		7
00	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
01	IME payment adjustment add on for managed care (see	28.01	0	0		0 0	0	8
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	о	0		o o	0	9
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9
	Disproportionate Share Adjustme		· · · · · ·			· · · · · · · · · · · · · · · · · · ·		1
. 00	Allowable disproportionate share percentage (see	33.00	0. 1517	0. 1517	0. 151	7 0. 1517		10
. 00	instructions) Disproportionate share adjustment (see instructions)	34.00	538, 747	0	127, 56	0 411, 187	538, 747	11
. 01	Uncompensated care payments	36.00	1, 254, 813	0	214, 48	0 1, 040, 333	1, 254, 813	11
. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	beneficiary d	i scharges 0		0 0	0	12
. 00	(see instructions) Subtotal (see instructions)	47.00	16, 167, 032	0	3, 796, 80	8 12, 370, 224	16, 167, 032	12
. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0	0,770,00	0 0	0	
. 00	(see instructions) Total payment for inpatient operating costs (see	49.00	16, 167, 032	0	3, 796, 80	8 12, 370, 224	16, 167, 032	15
. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50.00	1, 191, 056	0	291, 04	7 900, 009	1, 191, 056	16
. 00	if applicable) Special add-on payments for	54.00	О	0		0 0	0	17
2.01	new technologies Net organ aquisition cost	(0.00						17
7. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17

	Financial Systems		MARION GENERA	Provider C	NV 15 0011	Period:	u of Form CMS-2 Worksheet E	2002-1
LUW VU	LUME CALCULATION EXHIBIT 4			Provider C		From 07/01/2017 To 06/30/2018	Part A Exhibi	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
8.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18. C
19.00	SUBTOTAL			0	4, 087, 85	5 13, 270, 233	17, 358, 088	19 0
17.00	JUDIOTAL	W/S L, line	(Amounts from L)		4,007,00	13, 270, 233	17, 330, 000	17.0
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1, 155, 236					20.0
	Model 4 BPCI Capital DRG other than outlier	1.01	0			0 0	0	
21.00	Capital DRG outlier payments	2.00	35, 820	0	18, 70	6 17, 114	35, 820	21.0
21. 01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0 0	0	21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22.0
3. 00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23. (
.4.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24. (
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. (
6. 00	Total prospective capital payments (see instructions)	12.00	1, 191, 056	0	291, 04	7 900, 009	1, 191, 056	26. (
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
	Low volume adjustment factor Low volume adjustment	70. 96			0.00000	0.00000	0	27.0 28.0
8. 00	(transfer amount to Wkst. E, Pt. A, line)	70.90						28.0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.0
00.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. C

HUSPI	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 2:	pared:
				XVIII	Hospital Period on	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	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
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3, 363, 475	3, 363, 47	75	3, 363, 475	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10, 842, 099		10, 842, 099	10, 842, 099	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	167, 898	91, 29	76, 605	167, 898	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
	Indirect Medical Education Adjustment]
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	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	0.00000	0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
	Disproportionate Share Adjustment						
10.00		33.00	0. 1517	0. 151	0. 1517		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34.00	538, 747	127, 56	60 411, 187	538, 747	11.00
11. 01	instructions) Uncompensated care payments	36.00	1, 254, 813	214, 48	1, 040, 333	1, 254, 813	11 01
11.01	Additional payment for high percentage of ESR			214,40	1,040,333	1, 234, 013	11.01
12.00		46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	16, 167, 032	3, 796, 80	12, 370, 224	16, 167, 032	13.00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0		14.00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	16, 167, 032	3, 796, 80	08 12, 370, 224	16, 167, 032	15.00
16. 00		50.00	1, 191, 056	291, 04	900, 009	1, 191, 056	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17.00 17.01
17.02		68.00	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
40.00	SUBTOTAL			4, 087, 85	13, 270, 233	17, 358, 088	19 00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCU	LATION EXHIBIT 5			Period: From 07/01/2017 To 06/30/2018		pared:
		Title	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, 155, 236	272, 34	41 882, 895	1, 155, 236	20.00
20.01 Model 4 BPCI Capital DRG other than outlie	r 1.01	0		0 0	0	
21.00 Capital DRG outlier payments	2,00	35, 820	18, 70	17, 114	35, 820	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	•
22.00 Indirect medical education percentage (see		0.0000	0.000	0. 0000		22.00
instructions)	0100		0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see	6,00	0		0 0	0 0	23.00
instructions)						
24.00 Allowable disproportionate share percentag	e 10.00	0.0000	0.000	0.0000		24.00
(see instructions)						
25.00 Disproportionate share adjustment (see	11.00	0	1	0 0	0	25.00
instructions)						
26.00 Total prospective capital payments (see	12.00	1, 191, 056	291, 04	47 900, 009	1, 191, 056	26.00
instructions)						
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
		A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	0		0	0	
29.00 Low volume adjustment on or after October		0		0	0	
30.00 HVBP payment adjustment (see instructions)	70. 93	29, 496	9,69	95 19, 801	29, 496	
30.01 HVBP payment adjustment for HSP bonus	70.90	0		0 0	0	30. 01
payment (see instructions)						
31.00 HRR adjustment (see instructions)	70.94	-4, 337		0 -4, 337	-4, 337	
31.01 HRR adjustment for HSP bonus payment (see	70. 91	0		0 0	0	31.01
instructions)						
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see	70. 99			0 132, 857	132, 857	32.00
instructions)	.					100.00
100.00 Transfer HAC Reduction Program adjustment	το	Y				100. 00
Wkst. E, Pt. A.			l			I

	Financial Systems MARION GENERAL HOSP ATION OF REIMBURSEMENT SETTLEMENT Pro	11AL ovider CCN: 15-0011	Period:	u of Form CMS-2 Worksheet E	2552-10
0,12002			From 07/01/2017 To 06/30/2018	Part B	pared:
		Title XVIII	Hospi tal	11/26/2018 2: PPS	
			nospi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			1, 245	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	s)		20, 344, 211 18, 322, 471	2.00 3.00
4.00	Outlier payment (see instructions)			174, 022	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructio Line 2 times line 5	ns)		0. 000 0	5.00 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, Organ acquisitions	col. 13, line 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			1, 245	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			6 642	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0, 012	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			6, 642	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for paym	ent for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for page			0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)		-		17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 6, 642	
19.00	Excess of customary charges over reasonable cost (complete only i	fline 18 exceeds li	ne 11) (see	5, 397	
20.00	instructions)	6 11	10) (0	20.00
20.00	Excess of reasonable cost over customary charges (complete only i instructions)	F IINE II exceeds II	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			1, 245	21.00
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruct			0	22.00 23.00
23.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			18, 496, 493	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for CA	H see instructions		0 3, 665, 044	25.00 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			14, 832, 694	
	instructions)	50)			
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		0	28.00 29.00
30.00				14, 832, 694	
31.00	Primary payer payments			1,806	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			14, 830, 888	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			943, 620	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)		613, 353 636, 052	
37.00	Subtotal (see instructions)			15, 444, 241	
38.00	MSP-LCC reconciliation amount from PS&R			-226	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced	devices (see instruc	ctions)	0	39.98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 15, 444, 467	39.99 40.00
40.01	Sequestration adjustment (see instructions)			308, 889	
	Demonstration payment adjustment amount after sequestration			0	40.02
41.00 42.00	Interim payments Tentative settlement (for contractors use only)			15, 037, 121 0	41.00 42.00
43.00	Balance due provider/program (see instructions)			98, 457	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44.00
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00 92.00
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part I Date/Time Prep 11/26/2018 2:3	
		Title		Hospi tal	PPS	
		I npati ent	Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		15, 362, 73	2	14, 534, 080	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider			_		
3.01	ADJUSTMENTS TO PROVIDER	05/30/2018	85, 76	3 05/30/2018	503, 041	3. 01
3.02				0	0	3.02
3.03 3.04				0	0	3. 03 3. 04
3.04				0	0	3.02
0.00	Provider to Program	1		0		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53				0	0	3.53
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		85, 76	0	0 503, 041	3.54 3.99
J. 77	3, 50-3, 98)		05,70	5	505, 041	J. 7
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15, 448, 49	5	15, 037, 121	4.00
	TO BE COMPLETED BY CONTRACTOR	1 1				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. O´
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program	1		-1		
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51 5.52				0	0	5.52 5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)			-	-	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER			0	98, 457	6.01
6.02	SETTLEMENT TO PROGRAM		337, 02		0 15 125 570	6.02
7.00	Total Medicare program liability (see instructions)		15, 111, 47	Contractor	15, 135, 578 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	

			CCN: 15-T011	To 06/30/2018	B Date/Time Pre 11/26/2018 2:	
		Title	XVIII	Subprovider - IRF	PPS	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 372, 5	0	0000	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3.0
03				0	0	
04				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	3.
53				0	0	3.
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.
~~	3. 50-3. 98)		0 070 5			
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 372, 5	99	0	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	
03				0	0	5.
50	Provider to Program		1	0	0	5.
50 51	TENTATI VE TO PROGRAM			0		
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER			0	0	
02	SETTLEMENT TO PROGRAM		15, 9		0	
00	Total Medicare program liability (see instructions)		3, 356, 6		0	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems MARION GEN	IERAL HOSPI TAL	In Lie	u of Form CMS	6-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0011	Peri od: From 07/01/2017 To 06/30/2018		repared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT				
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL		4.4		1 1 00
1.00	Total hospital discharges as defined in AARA §4102 from V		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col				6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruction	ns)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions))			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	and line 31) (see instructior	ns)		32.00

		ERAL HOSPITAL		u of Form CMS-2	2552-
CALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2017	Worksheet E-3 Part III	
		Component CCN: 15-T011	To 06/30/2018	Date/Time Pre	
		Title XVIII	Subprovider -	11/26/2018 2: 3 PPS	38 piii
			IRF		
				1.00	
1.00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)			2 247 502	1. (
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			3, 367, 582 0. 0370	2.0
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			70, 382	3.
1. 00	Outlier Payments			52, 050	4.
5.00	Unweighted intern and resident FTE count in the most rece	ent cost reporting period en	ding on or prior	0.00	5.
5.00	to November 15, 2004 (see instructions)	ent cost reporting period en	ang on or prior	0.00	5.
5. 01	Cap increases for the unweighted intern and resident FTE	count for residents that wer	e displaced by	0.00	5.
	program or hospital closure, that would not be counted wi				•
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6.00	New Teaching program adjustment. (see instructions)			0.00	6.1
7.00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents with	thin the new program growth p	eriod of a "new	0.00	8.
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education a	adjustment (see instructions)		0.00	
0.00	5 5 7			7.345205	
1.00	5 5			0.00000	
2.00	5 5			0	12.
3.00		h		3, 490, 014	
4.00	5 5 1 5 1	truction)		0	14.
15.00 16.00	5 1 7	instructions)		0	15. 16.
7.00	15 51 1	Thisti uctions)		3, 490, 014	
8.00				3, 490, 014	
19.00	51515			3, 490, 014	
20.00				59, 556	
21.00				3, 430, 458	
22.00	,			5, 264	
23.00				3, 425, 194	
24.00		services) (see instructions)		0	24.
25.00		, , , , ,		0	25.
26.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	26.
27.00	Subtotal (sum of lines 23 and 25)			3, 425, 194	27.
8. 00	Direct graduate medical education payments (from Wkst. E-	-4, line 49)		0	28.
29.00	Other pass through costs (see instructions)			0	29.
30.00	1 5			0	30.
31.00				0	31.
31.50				0	
31. 99	1 3 3	tion		0	31.
32.00				3, 425, 194	
32.01	Sequestration adjustment (see instructions)			68, 504	
32.02		on			32.
33.00				3, 372, 599	
34.00		22,02,22 and 24		0 -15, 909	34. 25
35.00		· · · · · ·	chanter 1		
36.00	Protested amounts (nonallowable cost report items) in acc §115.2	LOI UAILLE WI LII CMS PUD. 15-2,	chapter I,	42, 489	36.
	TO BE COMPLETED BY CONTRACTOR				
50.00	5			52, 050	
51.00	5	าร)		0	51.
52.00	5			0.00	
53.00	Time Value of Money (see instructions)			0	53

CALCIII	Financial Systems MARION GENERAL F ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Peri od:	Worksheet E-3	2552-10
UNEOUL			From 07/01/2017 To 06/30/2018	Part VII Date/Time Pre 11/26/2018 2:3	pared:
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER COMPUTATION OF NET COST OF COVERED SERVICES	VICES FOR TITLES V OR X	IX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		704, 062		1.00
2.00	Medical and other services		701,002	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	-	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		704, 062	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		704.040	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		704, 062	0	7.00
	Reasonable Charges				-
8.00	Routi ne servi ce charges		678, 742		8.00
9.00	Ancillary service charges		1, 411, 238	0	1
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 089, 980	0	12.00
40.00	CUSTOMARY CHARGES	· · ·			10.00
13.00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for	navment for services o	n O	0	14.00
14.00	a charge basis had such payment been made in accordance with 4			0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.00
16.00	Total customary charges (see instructions)		2, 089, 980	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	1, 385, 918	0	17.00
	line 4) (see instructions)				10.00
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	ie O	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1		704, 062	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00 27.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	1
27.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		704, 062	0	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		704, 062	0	
32.00	Deducti bl es		0	0	
33.00			0	0	
34.00 35.00	Allowable bad debts (see instructions) Utilization review		0	0	34.00 35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	704, 062	0	1
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
38.00	Subtotal (line 36 ± line 37)		704, 062	0	1
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		704, 062	0	
	Interim payments		982, 291	0	41.00
41.00	1 3				
41.00 42.00 43.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordan		-278, 229	0	

MBURSEMENT - ALL OTHER HEAL DVERED SERVICES rvices transplant centers only) and 3) ents ments lines 5 and 6) r OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ent for services on a charge ole for payment for services with 42 CFR §413.13(e)	Subprovi der - IRF Inpati ent 1.00 XI X SERVI CES 27, 627 0 27, 627 0 27, 627 0 27, 627 0 27, 627 0 27, 627 0 41, 726	Part VI I Date/Time Prep 11/26/2018 2: 3 Cost 0utpati ent 2: 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
DVERED SERVICES rvices transplant centers only) and 3) ents ments lines 5 and 6) r OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	TH SERVICES FOR TITLES V OR ent for services on a charge of a for payment for services with 42 CFR §413.13(e)	I RF I npati ent 1.00 XI X SERVICES 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 20,654 0	Cost Outpatient 2.00 0 0 0 0 0 0 0 0 0 0 0 0
DVERED SERVICES rvices transplant centers only) and 3) ents ments lines 5 and 6) r OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ent for services on a charge ole for payment for services with 42 CFR §413.13(e)	Inpatient 1.00 XIX SERVICES 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 27,627 0 41,726 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
DVERED SERVICES rvices transplant centers only) and 3) ents ments lines 5 and 6) r OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ent for services on a charge ole for payment for services with 42 CFR §413.13(e)	XI X SERVICES 27, 627 0 27, 627 0 27, 627 0 27, 627 0 27, 627 0 27, 627 0 27, 627 0 41, 726 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
DVERED SERVICES rvices transplant centers only) and 3) ents ments lines 5 and 6) r OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ent for services on a charge ole for payment for services with 42 CFR §413.13(e)	27, 627 0 27, 627 0 27, 627 21, 072 20, 654 0 41, 726	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
rvices transplant centers only) and 3) ents ments lines 5 and 6) <u>FOR CHARGES</u> et of revenue computation <u>m of lines 8 through 11)</u> om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	0 27, 627 0 27, 627 21, 072 20, 654 0 0 41, 726	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
transplant centers only) and 3) ents ments lines 5 and 6) <u>F OR CHARGES</u> et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	0 27, 627 0 27, 627 21, 072 20, 654 0 0 41, 726	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
and 3) ents ments lines 5 and 6) F OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	0 27, 627 21, 072 20, 654 0 0 41, 726 0 0 0 0.00000 41, 726	0 0 0 0 0 0 0 0 0.000000 0
ents ments lines 5 and 6) r OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	0 27, 627 21, 072 20, 654 0 0 41, 726 0 0 0 0.00000 41, 726	0 0 0 0 0 0 0 0 0.000000 0
ments lines 5 and 6) <u>r OR CHARGES</u> et of revenue computation <u>m of lines 8 through 11)</u> om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	21, 072 20, 654 0 0 41, 726	0 0 0 0 0 0 0 0.000000 0
lines 5 and 6) F OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liable ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	21, 072 20, 654 0 0 41, 726	0 0 0 0 0 0 0 0.000000 0
r OR CHARGES et of revenue computation m of lines 8 through 11) om patients liable for paymen realized from patients liab ent been made in accordance (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	21, 072 20, 654 0 0 41, 726	0 0 0 0 0 0 0 0 0
et of revenue computation m of lines 8 through 11) om patients liable for payment realized from patients liab ent been made in accordance (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	20, 654 0 0 41, 726 0 0 0 0 0.00000 41, 726	0 0 0 0.000000 0
computation m of lines 8 through 11) om patients liable for paymen realized from patients liab ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	20, 654 0 0 41, 726 0 0 0 0 0.00000 41, 726	0 0 0 0.000000 0
computation m of lines 8 through 11) om patients liable for paymen realized from patients liab ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	20, 654 0 0 41, 726 0 0 0 0 0.00000 41, 726	0 0 0 0.000000 0
computation m of lines 8 through 11) om patients liable for paymen realized from patients liab ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	0 0 41, 726	0 0 0 0.000000 0
computation m of lines 8 through 11) om patients liable for paymen realized from patients liab ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	on 0 0.00000 41,726	0 0 0.000000 0
m of lines 8 through 11) om patients liable for paymen realized from patients liab ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	on 0 0.00000 41,726	0 0 0.000000 0
om patients liable for paymen realized from patients liab ent been made in accordance (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	on 0 0.00000 41,726	0 0 0.000000 0
realized from patients liab ent been made in accordance (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	on 0 0. 000000 41, 726	0 0. 000000 0
realized from patients liab ent been made in accordance (not to exceed 1.000000) instructions) over reasonable cost (comple	ole for payment for services with 42 CFR §413.13(e)	on 0 0. 000000 41, 726	0 0. 000000 0
ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	with 42 CFR §413.13(e)	0. 000000 41, 726	0. 000000 0
ent been made in accordance of (not to exceed 1.000000) instructions) over reasonable cost (comple	with 42 CFR §413.13(e)	0. 000000 41, 726	0. 000000 0
(not to exceed 1.000000) instructions) over reasonable cost (comple	,	41, 726	0
instructions) over reasonable cost (comple	ete only if line 16 exceeds	41, 726	0
over reasonable cost (comple	ete only if line 16 exceeds		
		11,077	
			Ŭ
er customary charges (comple	ete only if line 4 exceeds l	ine 0	0
5 5 . 1	3		
nstructions)		0	0
in a teaching hospital (see	e instructions)	0	0
ter the lesser of line 4 or		27, 627	0
Lines 22 through 26 must onl	ly be completed for PPS pro	vi ders.	
		0	0
		0	0
		0	
see instructions)		0	
e other pass through costs		0	0
rough 26)		0	0
r XIX PPS covered services of	ni y)		0
s 21 and 27) SETTLEMENT		27, 627	0
		0	0
	and (6)	Ű	0
2 20, prus 27 minus rines 5 i			0
		0	0
tructions)		0	0
		0	Ū
4 and 35 minus sum of lines	32 and 33)	27,627	0
UCTIONS) (SPECIFY)	/	0	0
· · · /		27, 627	0
			-
ation payments (from Wkst. E	-4)	01	0
ation payments (from Wkst. E provider (sum of lines 38 and		27, 627	01
		27, 627 9, 597	0
	tructions) 4 and 35 minus sum of lines JCTIONS) (SPECIFY)	d 20, plus 29 minus lines 5 and 6) tructions) 4 and 35 minus sum of lines 32 and 33) JCTIONS) (SPECIFY)	d 20, plus 29 minus lines 5 and 6) tructions) 4 and 35 minus sum of lines 32 and 33) JCTIONS) (SPECIFY) ation payments (from Wkst. E-4) 27, 627 0 27, 627 0 27, 627 0 27, 627 0 0 27, 627 0 0 0 0 0 0 0 0 0 0 0 0 0

	Financial Systems MARION GENERA E SHEET (If you are nonproprietary and do not maintain	Provider C		eri od:	Worksheet G	2552-
nd-t Iy)	ype accounting records, complete the General Fund column		T	rom 07/01/2017 0 06/30/2018	Date/Time Pre	
-		General Fund	Specific Purpose Fund	Endowment Fund	11/26/2018 2: Plant Fund	<u>38 pi</u>
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	11, 363, 807	0	0	0	1.
00	Temporary investments	761, 199	0	0	0	2.
00	Notes receivable	0	0	0	0	3.
00	Accounts receivable	59, 726, 520	0	0	0	4.
00	Other receivable	2, 257, 250	0	0	0	5.
00	Allowances for uncollectible notes and accounts receivable	-37, 325, 371	0	0	0	6.
00 00	Inventory Prepaid expenses	1, 266, 339 2, 807, 776	0	0	0	7. 8.
00	Other current assets	875, 009	0	0	0	9.
. 00	Due from other funds	0	0	0	0	10.
. 00	Total current assets (sum of lines 1-10)	41, 732, 529	0	0	0	11.
	FIXED ASSETS					
. 00	Land	4, 646, 549		0	0	12.
. 00 . 00	Land improvements Accumulated depreciation	3, 353, 531 -2, 593, 444	0	0	0	13. 14.
. 00	Buildings	132, 355, 722	0	0	0	14
. 00	Accumulated depreciation	-74, 557, 142	0	0	0	16
. 00	Leasehold improvements	3, 287, 381	0	0	0	17
. 00	Accumulated depreciation	-1, 966, 907	0	0	0	18
	Fixed equipment	3, 176, 435	0	0	0	19
. 00	Accumulated depreciation	-815, 421	0	0	0	20
	Automobiles and trucks Accumulated depreciation	1, 030, 472	0	0	0	21
	Major movable equipment	-768, 332 70, 648, 049	0	0	0	22
	Accumulated depreciation	-55, 480, 752	0	0	0	23
	Minor equipment depreciable	00,100,702	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
	Minor equipment-nondepreciable	4, 852, 203	0	0	0	29
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	87, 168, 344	0	0	0	30
00	Investments	245, 687, 872	10, 155	0	0	31
00	Deposits on leases	0	0	0	0	32
. 00	Due from owners/officers	0	0	0	0	33
. 00	Other assets	8, 086, 712	0	0	0	34
. 00	Total other assets (sum of lines 31-34)	253, 774, 584		0	0	35
. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	382, 675, 457	10, 155	0	0	36
. 00	Accounts payable	6, 272, 977	0	0	0	37
00	Salaries, wages, and fees payable	6, 634, 142	0	0	0	38
00	Payroll taxes payable	0	0	0	0	39
	Notes and Loans payable (short term)	0	0	0	0	40
	Deferred income	0	0	0	0	41
00	Accelerated payments Due to other funds	0	0	0	0	42 43
00	Other current liabilities	5, 034, 023	-	0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	17, 941, 142		0	0	
	LONG TERM LIABILITIES			- 1	-	
00	Mortgage payable	0	0	0	0	46
. 00	Notes payable	0	0	0	0	47
00	Unsecured Loans	0	0	0	0	48
00 00	Other long term liabilities	82,017,281	0	0	0	49 50
	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	82, 017, 281 99, 958, 423	-	0	0	50
00	CAPITAL ACCOUNTS	77, 750, 425	0	V	0	
00	General fund balance	282, 717, 034				52
00	Specific purpose fund		10, 155			53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00 00	Governing body created - endowment fund balance			0	0	56 57
00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57
00	replacement, and expansion				0	50
. 00	Total fund balances (sum of lines 52 thru 58)	282, 717, 034	10, 155	о	0	59
00	Total liabilities and fund balances (sum of lines 51 and	382, 675, 457	10, 155	o	0	60

Heal th	Financial Systems	MARION GENERA	L HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0011		riod: om 07/01/2017	Worksheet G-1	pared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00 265,984,067	3.00		4.00 10,155	5.00	1.00
1.00 2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	283, 984, 087 16, 732, 967 282, 717, 034		0	10, 155	0	1.00 2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00		0 0 0 0			0 0 0 0		0 0 0	6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	0 282, 717, 034		0 0 0	0 10, 155	0 0 0 0	10.00 11.00 12.00 13.00 14.00 15.00
15.00 16.00 17.00 18.00 19.00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 282, 717, 034		0	0 10, 155	0	15.00 16.00 17.00 18.00 19.00
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	7.00	8.00	0			1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00 9.00	Total additions (sum of line 4.0)		0 0 0 0 0		0			5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0		0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0			18.00 19.00

ΑΤΕΜ	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	: 15-0011	Peric From To	od: 07/01/2017 06/30/2018	Worksheet G-2 Parts I & II Date/Time Pre 11/26/2018 2:	pared:
	Cost Center Description		Inpati ent	0	utpati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
00	Hospi tal		21, 181, 80	04		21, 181, 804	1.0
00	SUBPROVIDER - IPF			0		0	2.0
00	SUBPROVIDER - IRF		3, 523, 6	60		3, 523, 660	3.0
00	SUBPROVI DER			0		0	4.0
0C	Swing bed - SNF			0		0	5.0
0C	Swing bed - NF			0		0	6.0
0C	SKILLED NURSING FACILITY						7.0
0C	NURSING FACILITY						8.0
0C	OTHER LONG TERM CARE						9.0
. 00	Total general inpatient care services (sum of lines 1-9)		24, 705, 40	64		24, 705, 464	10.0
	Intensive Care Type Inpatient Hospital Services			Ċ			1
. 00	INTENSIVE CARE UNIT		7, 015, 30	02		7, 015, 302	111. C
. 00	CORONARY CARE UNIT						12. C
. 00	BURN INTENSIVE CARE UNIT						13.0
. 00	SURGI CAL I NTENSI VE CARE UNI T						14.0
. 00	OTHER SPECIAL CARE (SPECIFY)						15.0
	Total intensive care type inpatient hospital services (sum of I	ines	7,015,30	02		7,015,302	16.0
	11-15)		,, -				
. 00	Total inpatient routine care services (sum of lines 10 and 16)		31, 720, 70	66		31, 720, 766	17.0
	Ancillary services		69, 962, 40		257, 627, 649	327, 590, 054	
	Outpatient services		11, 083, 50		67, 363, 361	78, 446, 869	
	RURAL HEALTH CLINIC		,,.	0	0	0	20.0
	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.0
	HOME HEALTH AGENCY			-	-	-	22.0
	AMBULANCE SERVICES			0	5, 705, 773	5, 705, 773	
	CMHC			-		-, ,	24.0
	AMBULATORY SURGICAL CENTER (D. P.)						25.0
	HOSPICE						26.0
	PROFESSIONAL FEES			0	30, 009, 629	30, 009, 629	
	SELF INSURANCE REVENUE		899, 5	39	3, 914, 417	4, 813, 956	
	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	113, 666, 2		364, 620, 829	478, 287, 047	
	G-3, line 1)		-, ,			, . ,	
	PART II - OPERATING EXPENSES			÷			1
. 00	Operating expenses (per Wkst. A, column 3, line 200)				172, 347, 571		29.0
00	ADD (SPECIFY)			0			30. (
00				0			31. (
00				0			32.0
00				0			33.0
00				0			34. (
00				0			35. (
00	Total additions (sum of lines 30-35)				0		36. (
00	ELIMINATING ENTRY		1,063,4	52			37.0
00				0			38.0
00				0			39.0
. 00				0			40.0
00				0			41.0
	Total deductions (sum of lines 37-41)			Ĭ	1, 063, 452		42.0
	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer			171, 284, 119		43.0
00	to Wkst. G-3, line 4)			1	1, 1, 204, 117		-5.0

STATEMENT OF REVENUES AND EXPENSES Provider CON: 15-0011 Period: From 07/01/2011 Period: To 007/01/2011 Worksheet G-3 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 478, 287, 047 1.00 2.00 Less contractual allowances and discounts on patients' accounts 306, 764, 96 2.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 171, 284, 194, 400 237, 932 5.00 Net income from neses (from Wkst. G-2, Part II, line 43) 171, 124, 119 4.00 6.00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 0 18, 073, 181 7.00 8.00 Revenue from telephone and other miscel aneous communication services 0 18, 073, 181 7.00 9.00 Revenue from television and radio service 0 10, 00 10, 00 10, 00 11.00 Revenue from television and radio service 0 10, 00 10, 00 10, 00 12.00 Revenue from television and radio service 0 10, 00 10, 00 10, 00 13.00 Revenue from sels soil to enployees and guests 0 10, 00 10, 00	Health Financial Systems		MARION GENERAL HOSPITAL		In Lieu of Form CMS-2552-10		
1.00 Total patient revenues (from Wkst G-2, Part I, column 3, Line 28) 478, 287, 047 1.00 2.00 Less contractual allowances and discounts on patients' accounts 306, 764, 996 2.00 3.00 Net patient revenues (line 1 minus line 2) 171, 522, 051 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 171, 284, 119 4.00 0.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 237, 932 5.00 0.01 Contributions, donations, bequests, etc 0 6.00 6.00 0.00 Revenues from telephone and other miscel laneous communication services 0 18, 073, 181 7.00 8.00 Revenue from television and radio service 0 9.00 8.00 9.00 10.00 Parking lot receipts 0 11.00 12.00 13.00 10.00 Revenue from meals sold to employees and guests 0 12.00 13.00 10.00 Revenue from sale of drugs to other than patients 0 14.00 10.00 Revenue from sale of drugs to other than patients 0 16.00				Provi der CCN: 15-0011	Period: From 07/01/2017	7 8 Date/Time Prepared:	
1.00 Total patient revenues (from Wkst G-2, Part I, column 3, Line 28) 478, 287, 047 1.00 2.00 Less contractual allowances and discounts on patients' accounts 306, 764, 996 2.00 3.00 Net patient revenues (line 1 minus line 2) 171, 522, 051 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 171, 284, 119 4.00 0.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 237, 932 5.00 0.01 Contributions, donations, bequests, etc 0 6.00 6.00 0.00 Revenues from telephone and other miscel laneous communication services 0 18, 073, 181 7.00 8.00 Revenue from television and radio service 0 9.00 8.00 9.00 10.00 Parking lot receipts 0 11.00 12.00 13.00 10.00 Revenue from meals sold to employees and guests 0 12.00 13.00 10.00 Revenue from sale of drugs to other than patients 0 14.00 10.00 Revenue from sale of drugs to other than patients 0 16.00						1 00	
2.00 Less contractual al lowances and discounts on patients' accounts 306,764,996 2.00 3.00 Net patient revenues (line 1 minus line 2) 171,522,051 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 171,224,119 4.00 5.00 Net income from service to patients (line 3 minus line 4) 237,932 5.00 0.01 Income from investments 18,073,181 7.00 8.00 Revenue from television and radio service 0 6.00 9.00 Revenue from television and radio service 0 10.00 0.00 Purchase discounts 0 10.00 10.00 Revenue from television and radio service 0 10.00 10.00 Revenue from television and radio service 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from sale of medical and surgical supplies to other than patients 0 14.00 14.00 Revenue from sale of medical records and abstracts 0	1.00	Total patient revenues (from Wkst, G-2, Par	rt L. column 3. line	28)			1.00
3.00 Net patient revenues (line 1 minus line 2) 171, 522, 051 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 171, 284, 119 4.00 0.00 Contributions, donations, bequests, etc 0 6.00 0 6.00 0.01 Income from investments 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 9.00 8.00 9.00 8.00 9.00 8.00 9.00 8.00 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 0 10.00 9.00 0 10.00 0 10.00 0							
5.00Net income from service to patients (line 3 minus line 4)237,9325.00OTHER INCOMEOTHER INCOME00	3.00		· . · · · · · · · · · · · · · · · · · ·				3.00
OTHER I NCOME 0 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 18,073,181 7.00 18,073,181 7.00 8.00 Revenues from tel ephone and other miscel laneous communication services 0 9.00 9.00 Revenue from tel ephone and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 12.00 14.00 Revenue from rental of living quarters 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of textbooks, uniforms, etc.) 0 18.00 18.00 10.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 22.00 10.00 Rental of hospital space 0 23.00 23.00 23.00 24.01 <t< td=""><td>4.00</td><td colspan="5"></td><td>4.00</td></t<>	4.00						4.00
6.00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 18,073,181 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 18,073,181 7.00 9.00 Revenue from television and radio service 0 9.00 0 0 9.00 0 0 9.00 0 0 9.00 0 0 9.00 0 0 9.00 0 0 9.00 0 0 9.00 0 0 0 9.00 0 0 0 0 0 9.00 0 0 10.00 0 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 12.00 13.00 13.00 13.00 0 12.00 13.00 13.00 14.00 15.00 15.00 16.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 19.00 17.00 18.00 17.00	5.00						5.00
7.00 Income from investments 18,073,181 7.00 8.00 Revenue from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from telephone and radio service 0 0 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from reals sold to employees and guests 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 18.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 19.00 10.00 Rental of hospital space 0 21.00 22.00 23.00 Governmental appropriations 0 21.00 22.00 24.00 There NERATING REVENUE 1,736,062 24.00 22.00 23.00 Governmental appropriations 0 21.00		OTHER INCOME					
8.00 Revenues from telephone and other miscellaneous communication services 0 9 0 9.00 Revenue from television and radio service 0 9 00 0.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 10.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from meals sold to employees and guests 0 14.00 14.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tui tion (fees, sale of textbooks, uniforms, etc.) 0 18.00 20.00 Revtal of hospital space 0 21.00 21.00 Revalue from gifts, flowers, coffee shops, and canteen 0 22.00 21.00 Retail of hospital space 0 22.00 22.00 Retail of hospital space 0 23.00 23.00 Governmental appropriations 0 24.01 24.01 UMREALIZED GAIN/LOSS -5.912.065 24.01 <td< td=""><td>6.00</td><td>Contributions, donations, bequests, etc</td><td></td><td></td><td></td><td>0</td><td>6.00</td></td<>	6.00	Contributions, donations, bequests, etc				0	6.00
9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from reals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Rental of vending machines 0 21.00 21.00 Rental of hospital space 0 22.00 22.00 Rental of hospital appropriations 0 23.00 24.00 DTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,512,065 24.02 25.00 Total other income (sum of lines 6-24) <t< td=""><td>7.00</td><td>Income from investments</td><td></td><td></td><td></td><td>18, 073, 181</td><td>7.00</td></t<>	7.00	Income from investments				18, 073, 181	7.00
10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 16.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 24.01 24.00 DTHEN OPERATING REVENUE 1,736,062 24.02 25.00 Total other income (sum of lines 6-24) 16,388,229 25.00 26.00 Total	8.00	Revenues from telephone and other miscellaneous communication services					8.00
11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 17.00 Revenue from sale of fungs to other than patients 0 18.00 18.00 Revenue from sale of fungs to other than patients 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Rental of vending machines 0 21.00 21.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.01 PENSION 1, 736,062 24.00 24.01 PENSION 16,388,229 25.00 25.00 Total other income (sum of lines 6-24) 16,388,229 25.00 26.00 Total (line 5 plus line 25)							
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13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from sale of textbooks, uniforms, etc.) 0 18.00 10.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 21.00 Rental of hospital space 0 22.00 22.00 Rental of hospital space 0 23.00 24.00 OTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,491,051 24.02 25.00 Total other income (sum of lines 6-24) -5,912,065 24.02 25.00 Total (line 5 plus line 25) 16,626,161 26.00 26.00 Total (line 5 plus line 27 and subscripts) -106,806 28.00						-	
14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,491,051 24.01 24.02 UNREALIZED GAIN/LOSS -5,912,065 24.02 25.00 Total other income (sum of lines 6-24) 16,626,161 26.00 26.00 Total other expenses (sum of line 27 and subscripts) -106,806 27.00						-	
15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 16.00 18.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 1, 736, 062 24.00 24.01 PENSION 2, 491, 051 24.01 24.02 UNREALIZED GAIN/LOSS -5, 912, 065 24.02 25.00 Total other income (sum of lines 6-24) 16, 388, 229 25.00 26.00 Total (line 5 plus line 25) 16, 626, 161 26.00 -106, 806 27.00 27.00 BAD DEBT -106, 806 27.00						-	
16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,491,051 24.01 24.02 UNREALIZED GAIN/LOSS -5,912,065 24.02 25.00 Total other income (sum of lines 6-24) -5,912,065 24.02 26.00 Total other expenses (sum of line 27 and subscripts) -106,806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106,806 28.00						-	
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20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,491,051 24.01 24.02 UNREALIZED GAIN/LOSS 2,491,051 24.01 25.00 Total other income (sum of lines 6-24) 16,388,229 25.00 26.00 Total (line 5 plus line 25) 16,626,161 26.00 27.00 BAD DEBT -106,806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106,806 28.00						-	
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22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,491,051 24.01 24.02 UNREALIZED GAIN/LOSS 2,491,051 24.01 25.00 Total other income (sum of lines 6-24) 16,388,229 25.00 26.00 Total (line 5 plus line 25) 16,626,161 26.00 27.00 BAD DEBT -106,806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106,806 28.00		5	and canteen			-	
23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,491,051 24.01 24.02 UNREALIZED GAIN/LOSS -5,912,065 24.02 25.00 Total other income (sum of lines 6-24) -5,912,065 26.00 26.00 Total other expenses (sum of line 27 and subscripts) -106,806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106,806 28.00					0		
24.00 OTHER OPERATING REVENUE 1,736,062 24.00 24.01 PENSION 2,491,051 24.01 24.02 UNREALIZED GAIN/LOSS -5,912,065 24.02 25.00 Total other income (sum of lines 6-24) 16,388,229 25.00 26.00 Total (line 5 plus line 25) 16,626,161 26.00 27.00 BAD DEBT -106,806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106,806 28.00					-		
24. 01PENSI ON2, 491, 05124. 0124. 02UNREALI ZED GAI N/LOSS-5, 912, 06524. 0225. 00Total other income (sum of lines 6-24)16, 388, 22925. 0026. 00Total (line 5 plus line 25)16, 626, 16126. 0027. 00BAD DEBT-106, 80627. 0028. 00Total other expenses (sum of line 27 and subscripts)-106, 80628. 00						-	
24. 02 UNREALIZED GAIN/LOSS -5,912,065 24. 02 25. 00 Total other income (sum of lines 6-24) 16,388,229 25. 00 26. 00 Total (line 5 plus line 25) 16,626,161 26. 00 27. 00 BAD DEBT -106,806 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) -106,806 28. 00							
25.00 Total other income (sum of lines 6-24) 16, 388, 229 25.00 26.00 Total (line 5 plus line 25) 16, 626, 161 26.00 27.00 BAD DEBT -106, 806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106, 806 28.00							
26.00 Total (line 5 plus line 25) 16,626,161 26.00 27.00 BAD DEBT -106,806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106,806 28.00							
27.00 BAD DEBT -106,806 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -106,806 28.00		, , ,					
28.00Total other expenses (sum of line 27 and subscripts)-106,80628.00							
29.00 Net income (or Loss) for the period (line 26 minus line 28) 16,732,967 29.00							
	29.00	Net income (or loss) for the period (line 2	26 minus line 28)			16, 732, 967	29.00

LCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0011	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Pre			
			11/26/2018 2:3	38 pr		
· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS			
			1.00			
PART I - FULLY PROSPECTIVE METHOD			1.00			
CAPITAL FEDERAL AMOUNT						
00 Capital DRG other than outlier						
01 Model 4 BPCI Capital DRG other than outlier			1, 155, 236 0			
00 Capital DRG outlier payments			35, 820	2.		
01 Model 4 BPCI Capital DRG outlier payments			0	2.		
00 Total inpatient days divided by number of days in the	Total inpatient days divided by number of days in the cost reporting period (see instructions)					
00 Number of interns & residents (see instructions)	0.00	4.				
00 Indirect medical education percentage (see instructio	0.00	5.				
00 Indirect medical education adjustment (multiply line 1.01) (see instructions)	0	6.				
00 Percentage of SSI recipient patient days to Medicare 30) (see instructions)	0.00					
00 Percentage of Medicaid patient days to total days (se	0.00					
) Sum of Lines 7 and 8				9.		
0 Allowable disproportionate share percentage (see instructions)				10.		
. 00 Disproportionate share adjustment (see instructions)			0	1		
.00 Total prospective capital payments (see instructions)			1, 191, 056	12.		
			1.00			
PART II - PAYMENT UNDER REASONABLE COST			1.00			
00 Program inpatient routine capital cost (see instructi	005)		0	1 1.		
00 Program inpatient ancillary capital cost (see instruct			0	1		
Total inpatient program capital cost (line 1 plus line 2)				3.		
Capital cost payment factor (see instructions)				4.		
00 Capital cost payment factor (see instructions) 00 Total inpatient program capital cost (line 3 x line 4)		0			
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00			
00 Program inpatient capital costs (see instructions)			0	1 1		
00 Program inpatient capital costs for extraordinary cir	cumstances (see instructions)		0			
00 Net program inpatient capital costs (line 1 minus lin			0	3.		
00 Applicable exception percentage (see instructions)			0.00	4.		
00 Capital cost for comparison to payments (line 3 x lin	Capital cost for comparison to payments (line 3 x line 4)			5.		
Percentage adjustment for extraordinary circumstances (see instructions)			0.00	6		
Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0			
Capital minimum payment level (line 5 plus line 7)				8.		
Current year capital payments (from Part I, line 12, as applicable)				9 10		
 .00 Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) .00 Net comparison of capital minimum payment level to ca 		5	0			
				1		
.00 Current year exception payment (if line 12 is positiv			0			
	I over capital payment for the f	ollowing period	0	14.		
.00 Carryover of accumulated capital minimum payment leve	1 1 2	0 1				
.00 Carryover of accumulated capital minimum payment leve (if line 12 is negative, enter the amount on this lin	e)	0.1		1-		
.00 Carryover of accumulated capital minimum payment leve	e) (see instructions)		0			