(Si gned) TONY ROBERTS

Officer or	Admi ni strator	of	Provider(s	.)
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CF0 Title

(Dated when report is electronically signed.)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	398, 899	-116, 711	0	-881, 688	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	20, 113	0		10, 336	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	419, 012	-116, 711	0	-871, 352	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.

PI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	ATA	Provi de	er CCN:	15-0011	Period: From 07/01	/2019		heet S-2 I	2
)/2020	Date/	Time Pre /2020 1:	
	1.00	2.	00	:	3.00			4.00	11720	2020 1.	
~	Hospital and Hospital Health Care Co										1
	Street: 441 WABASH AVENUE City: MARION	PO Box: State: I	N Z	Zip Code	: 46952	- Cour	ty: GRANT				1.
	· · · · ·	Component Na	ame	CCN	CBSA	Provi de	r Date			stem (P,	
			N	Number	Number	r Type	Certified		<u>, 0, o</u> XVII		-
		1.00		2.00	3.00	4.00	5.00	6.00			-
	Hospital and Hospital-Based Componer										
0 0	Hospital Subprovider – IPF	MARION GENERAL H	OSPI TAL 1	150011	99915	1	07/01/196	6 N	P	0	3.
0	Subprovi der – IRF	MARION GENERAL H REHAB	OSPI TAL 1	15T011	99915	5	07/01/200	5 N	P	0	5
0 0	Subprovider - (Other) Swing Beds - SNF										6
0	Swing Beds - NF										8
0	Hospital-Based SNF										9
00 00	Hospital -Based NF										10
00	Hospital-Based OLTC Hospital-Based HHA										11
00	Separately Certified ASC										13
00	Hospital-Based Hospice										14
00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15
00	Hospital -Based (CMHC) I										17
	Renal Dialysis Other										18
00							From	 ກ:	Т	Го:	17
							1.0			. 00	
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						07/01/	2019	06/3	0/2020	20
											_
	Inpatient PPS Information					1.00	2.0	0	3	. 00	
00	Does this facility qualify and is it					Y	N				22.
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo								ĺ		
	facility subject to 42 CFR Section §								ĺ		
	hospital?) In column 2, enter "Y" fo	or yes or "N" for	no.								
01	Did this hospital receive interim ur cost reporting period? Enter in colu					Ν	Y		ĺ		22
	the portion of the cost reporting pe								ĺ		
	Enter in column 2, "Y" for yes or "N				ost				Í		
02	reporting period occurring on or aft Is this a newly merged hospital that				e	Ν	N		ĺ		22
02	payments to be determined at cost re	port settlement?	(see inst	truction	s)				Í		1 22
	Enter in column 1, "Y" for yes or "N								ĺ		
	cost reporting period prior to Octob or "N" for no, for the portion of th										
	October 1.										
03	Did this hospital receive a geograph rural as a result of the OMB standar					Ν	N		ĺ	Ν	22
	adopted by CMS in FY2015? Enter in c								Í		
	for the portion of the cost reportir	ng period prior to	o October	1. Ente					ĺ		
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft	no tor the portion	on of the ee instruc	cost ctions)							
	Does this hospital contain at least	100 but not more	than 499	beds (a					ĺ		
	counted in accordance with 42 CFR 41	2.105)? Enter in	column 3,	"Y" fo	r				ĺ		
00	yes or "N" for no. Which method is used to determine Me	edicaid days on li	ines 24 ar	nd/or 25			3 N				23
	below? In column 1, enter 1 if date	of admission, 2 i	if census	days, o	r 3						
	if date of discharge. Is the method reporting period different from the				UST						
	reporting period? In column 2, enter		"N" for r	10.							
			In-State Medicaid			Out-of State	Out-of State	Medica HMO da		Other edi cai d	
			pai d days			Medi cai d	Medi cai d	TIMO UZ		days	
			,	unpa	id pa	aid days	eligible				
			1.00	day 2.0		3.00	unpai d 4.00	5.00		6.00	-
	If this provider is an IPPS hospital	, enter the	57		491	3.00	4.00		419		0 24
00											
00	in-state Medicaid paid days in colum					1			1		
00	Medicaid eligible unpaid days in col	umn 2,									
00		umn 2, column 3, d days in column									

	Financial Systems MARIO TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	N GENERAL HO	Provider CC	N: 15-0011	Peri od:		Workst	rm CMS- neet S-2	
					From 07/0 To 06/3	01/2019 30/2020	Date/1	ime Pre 2020 1:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	nid (nys Me	Other di cai d days	
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	1.00	2.00	3.00	4.00		123	6.00	25.
					Urban/F	Rural S 00		f Geogr 00	· -
5.00 7.00	Enter your standard geographic classification (not v cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not v reporting period. Enter in column 1, "1" for urban of	or rural. vage) status	s at the en	d of the co		2 2			26. 27.
5.00	enter the effective date of the geographic reclassi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	fication in	column 2.			1		1	35.
					Begi n 1.	00	2.	i ng: 00	
	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent da If this is a Medicare dependent hospital (MDH), enter	tes.	·			/2019 0	06/30)/2020	36. 37.
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y" t instructions)								37.
. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.								38.
					Y/			/N 00	-
9. 00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction), (ii), or the mileage ii)? Enter	(iii)? En e requireme in column	ter in colu nts in 2 "Y" for y	mn es			N	39. 40.
	"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October			yes or "N"	for		XVIII	XIX	
	Description Downant Contan (DDC) Carital					1.00	_	_	_
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	ent for disp	proporti ona	te share in	accordance	e N	N	N	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exe pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.
7.00 8.00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals					N N	N N	N N	47. 48.
. 00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting	impacted by no in colu	/ CR 11642 umn 2.	(or subseque	ent CR), MA				56.
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "N nth of this 'Y", complet	l" for no i cost repor ce Workshee	n column 1. ting period	ור If column ? Enter יי	("			
. 00	If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	nbursement f	°or physici	ans' servi c	es as	N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If ye	•		, Pt. I. NAHE 413.8 Y/N	35 Worksh Lin	N neet A e #	Qualif Crit	hrough ication erion	59.
			sts for	1.00 N	2.	00		ode 00	60.

0381 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider C		eriod: rom 07/01/2019 o 06/30/2020	Worksheet S-2 Part I Date/Time Pre 11/20/2020 1:	pared:
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.0
	column 1. (see instructions)						
1. 01	Enter the average number of unweighted primary care						61.0
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						
	instructions)						
1. 02	Enter the current year total unweighted primary care						61.0
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
1. 03	Enter the base line FTE count for primary care						61.0
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see instructions)						
1.04	Enter the number of unweighted primary care/or						61.0
	surgery allopathic and/or osteopathic FTEs in the						
1 05	current cost reporting period.(see instructions). Enter the difference between the baseline primary						61.0
	and/or general surgery FTEs and the current year's						
	primary care and/or general surgery FTE counts (line						
1 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being						61.0
	used for cap relief and/or FTEs that are nonprimary						
	care or general surgery. (see instructions)	Dro	Arom Namo	Program Code	Upwoi abtod	Upwai abtad	
			ogram Name		Unweighted	Unweighted Direct GME	
						FTE Count	
1 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
1. 10	special ty, if any, and the number of FTE residents				0.00	0.00	01.
	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.						
1.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0.00	0.00	61.2
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column						
	3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
				1			
	ACA Provisions Affecting the Health Resources and Ser	rvi ces	Administration	n (HRSA)		1.00	
2.00	Enter the number of FTE residents that your hospital				iod for which	0.00	62.0
0 01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a		ing Hoolth Cor	ator (THC) into	Nour bosnital	0.00	62.0
2.01	during in this cost reporting period of HRSA THC prog				your nospital	0.00	02.0
	Teaching Hospitals that Claim Residents in Nonprovide	er Sett	i ngs				
3.00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N	63.0
				Unweighted	Unweighted	Ratio (col.	
				FTEs	FTEs in	1/ (col . 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
				1.00	2.00	3.00	1
	Section 5504 of the ACA Base Year FTE Residents in No	•	0				
		re June			0.00	0. 000000	64 0
1 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit		ned residents				1 U4.L
4. 00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor	ty traiı		0.00	0.00	0.000000	
4. 00	Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in	ty train n-priman all non	ry care nprovi der	0.00	0.00	0.00000	
H. 00	Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor	ty train n-priman all non d non-pr	ry care nprovider rimary care	0.00	0.00	0.00000	

	EX IDENTIFICATION D	AIA Provider C		eriod: com 07/01/2019	Worksheet S-2 Part I	2
			To		Date/Time Pre	epare
	Program Name	Program Code	Unweighted	Unweighted	11/20/2020 1: Ratio (col.	17 p
			FTEs	FTEs in	3/ (col . 3 +	
			Nonprovi der	Hospi tal	col. 4))	
-	1.00	2.00	Si te 3.00	4.00	5.00	-
00 Enter in column 1, if line 63	1.00	2.00	0.00) 65.
is yes, or your facility						
trained residents in the base						
year period, the program name associated with primary care						
FTEs for each primary care						
program in which you trained						
residents. Enter in column 2, the program code. Enter in						
column 3, the number of						
unweighted primary care FTE						
residents attributable to						
rotations occurring in all						
non-provider settings. Enter in column 4, the number of						
unweighted primary care						
resident FTEs that trained in						
your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column						
4)). (see instructions)						
			Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	1/ (col. 1 + col. 2))	
			Si te	nospi tui		
			1.00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Settin	gsEffective f	or cost report	ing periods	
beginning on or after July 1, 201 .00 Enter in column 1 the number of u		· · · ·			0,00000	
		nrv care resident	0.00	0 00		0 66 (
FTEs attributable to rotations of			0.00	0.00	0. 000000	66.
FTEs attributable to rotations oc Enter in column 2 the number of u	ccurring in all nonp unweighted non-prima	provider settings. ary care resident	0.00	0.00	0.00000	0 66.0
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00	0.00	0. 00000) 66.(
FTEs attributable to rotations oc Enter in column 2 the number of u	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00	0.00	Ratio (col.	0 66.0
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u>	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u>	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unwei ghted	Ratio (col.	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u>	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents.	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + column 2 divided by (column 2 divided by (col	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable 	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
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 FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in 	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	_
 FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) 	ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	_
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>25</u> chiatric Facility (Provi der settings. Ary care resident 3 the ratio of Instructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	2.00	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.00000000	70.0
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>25</u> uchiatric Facility (the facility have a	TPF), or does it con	Unweighted FTEs Nonprovider Site 3.00 0.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	70.0
 FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the resident FTEs that trained in your hospital. Enter in column 4, the number of unweighted primary care FTE resident Primary care for (column 3, the resident FTEs that trained in your hospital. Enter in column 4, the rum 4, the column 3, the ratio of (column 3, the ratio of (column 3, the ratio of (column 4, 1). (see instructions) Inpatient Psychiatric Facility PP 00 Is this facility an Inpatient Psychatric Form. O0 If line 70 is yes: Column 1: Did recent cost report filed on or be 	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>25</u> ychiatric Facility (the facility have a efore November 15, 2	TPF), or does it con approved GME teach	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in f yes or "N" for t	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.00000000	70. (
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 01 Inpatient Psychiatric Facility PF 00 02 Inpatient Psychiatric Facility PF or yes or "N" for no. 00	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>25</u> ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac	TIPF), or does it con approved GME teach (1) Friday train resident (1) The first train the first train the first train train (1) The first train train train train train train train (1) The first train tra	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in f yes or "N" for is	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 0.00 0.00 1.00 0.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.00000000	
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412. 424(d) (1) (iii) (c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic	22 22 23 24 25 25 25 25 25 25 25 25 25 25	provi der settings. ary care resident 3 the ratio of istructions) Program Code 2.00 2.00 (IPF), or does it con approved GME teach 2004? Enter "Y" for cility train resident)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in yes or "N" for is s in a new teacl yes or "N" for is	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.00000000	70. (
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions)	<pre>ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 25 ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d) (1) (iii cate which program y</pre>	provi der settings. ary care resident 3 the ratio of istructions) Program Code 2.00 2.00 (IPF), or does it con approved GME teach 2004? Enter "Y" for cility train resident)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in yes or "N" for is s in a new teacl yes or "N" for is	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.00000000	70.0
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412. 424(d) (1) (iii) (c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic	ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 25 ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y y PPS	TPF), or does it con an approved GME teach (1PF), or does it con an approved GME teach (10)? Enter "Y" for cear began during thi	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in f yes or "N" for in s in a new teach yes or "N" for in s cost reporting	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.00000000	70

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020		repared:
		1.0	0 2.00 3.0	0
6.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting period.	2004? Enter "Y" for yes ng program in accordar Jumn 3: If column 2 is	n the most N s or "N" for nce with 42 s Y,		76.00
Long Term Care Hospital PPS			1.00	_
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an 1.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. TEFRA Providers		ng period? Ente	~ N N	80.00 81.00
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 6.00 Did this facility establish a new Other subprovider (excluded u			N	85.00 86.00
 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospital c 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 	lassified under sectio	n	N	87.00
		V 1.00	XIX	_
Title V and XIX Services		1.00	2.00	
0.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.			Y	90.00
 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applica 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual 	ıble column.	Ν	Y	91.00
instructions) Enter "Y" for yes or "N" for no in the applicable 3.00 Does this facility operate an ICF/IID facility for purposes of	e column.	- N	N	92.00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and		N	N	94.00
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applic 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or		0. 00 N	0. 00 N	95.00 96.00
 applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the applic 8.00 Does title V or XIX follow Medicare (title XVIII) for the interstepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for 	rns and residents post	0. 00 Y	0. 00 Y	97.00 98.00
 column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX. 			Y	98.01
8.02 Does title V or XIX follow Medicare (title XVIII) for the calcu bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "		Y	Y	98.02
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critica reimbursed 101% of inpatient services cost? Enter "Y" for yes c			N	98.03
<pre>for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.</pre>		N	Ν	98.04
8.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.			Y	98.05
8.06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. Rural Providers		Y	Y	98.06
05.00Does this hospital qualify as a CAH? 06.00If this facility qualifies as a CAH, has it elected the all-inc	lusive method of payme	N ent N		105.00 106.00
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF a Enter "Y" for yes or "N" for no in column 2. (see instructions	(see instructions) I train I&Rs in an Ind/or IRF unit(s)?	N		107.00
08.00 s this a rural hospital qualifying for an exception to the CRN (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		2 N		108.00

ealth Financial Systems MARION GENERAL NOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider (eriod: com 07/01/2019	eu of Form CMS Worksheet S- 9 Part I	
		Tc		Date/Time Pr	
	Physi cal	Occupati onal	Speech	11/20/2020 1 Respi ratory	
	1.00	2.00	3.00	4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	-
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes o	r "N" for no. I	f yes,	N	110.00
			1.00	2.00	_
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111.00
		1.00	2.00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes				
16.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	Y			116.00
17.00 s this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.		Y			117.00
18.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr					118.00
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
18.01 List amounts of malpractice premiums and paid losses:		1, 414, 149		0	0118.01
			1.00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 19.00 DO NOT USE THIS LINE			Ν		118.02
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.	n column 1, ['] " ualifies for	Y" for yes or the Outpatient	Ν	N	120.00
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devic	es charged to	Ν		121.00
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information			N		122.00
25.00Does this facility operate a transplant center? Enter "Y" fo	or yes and "N	" for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2		ification date			126.00
IT COLUMN I AND LEIMINALION VALE, IT ADDITCADLE. IN COLUMN 2	ter the certi	fication date			127.00
27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2				1	128.00
 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	ter the certi 2.				
 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2. 	ter the certi 2. er the certif	ication date in			129.00
 27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, enter 	ter the certi 2. er the certif enter the ce umn 2.	ication date in rtification			129.00 130.00

Health Financial Systems	MARI ON GENERA	L HOSPI TAL			In Lieu	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-0011		: 7/01/2019	Worksheet S-2 Part I	
					6/30/2020	Date/Time Pre	
						11/20/2020 1:	17 pm
					1.00	2.00	
132.00 If this is a Medicare certified is in column 1 and termination date,			ication d	ate			132.00
133. 00 Removed and reserved	TT applicable, Th column	Ζ.					133.00
134.00 If this is an organ procurement or		he OPO number	in column	1			134.00
and termination date, if applicabl All Providers	e, in column 2.						
140.00 Are there any related organization	or home office costs as	defined in CMS	Pub. 15-	1,	N		140.00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office c				
are claimed, enter in column 2 the	home office chain number 2.0		tions)		3.00		
If this facility is part of a chai			ugh 143 t	he name ar		of the home	
office and enter the home office of		ctor number.	Carata	antral a Nu			1 4 1 . 00
141.00Name: 142.00Street:	Contractor's Name: PO Box:		Contr	actor's Nu	imper:		141.00
143. 00 Ci ty:	State:		Zip C	ode:			143.00
						1.00	
144.00 Are provider based physicians' cos	sts included in Worksheet	A?				1.00 Y	144.00
						•	
145 00 0			<u> </u>		1.00	2.00	1.45 00
145.00 If costs for renal services are cl inpatient services only? Enter "Y"				is			145.00
no, does the dialysis facility inc	lude Medicare utilization						
period? Enter "Y" for yes or "N"		uolu filad aaa	+ =====+2		N		146.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir					Ν		140.00
yes, enter the approval date (mm/c							
						1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			N 1.00	147.00
148.00 Was there a change in the order of	allocation? Enter "Y" fo	r yes or "N" f	or no.			N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? E	nter "Y" for y Part A	es or "N" Part		itle V	N Title XIX	149.00
		1.00	2.00		3.00	4.00	
Does this facility contain a provi	der that qualifies for an	exemption fro	om the app	lication c	of the low	er of costs	
or charges? Enter "Y" for yes or ' 155.00Hospital	N° for no for each compon	N	A and Part	B. (See 4	1 <u>2 CFR 941</u> N	3. 13) N	155.00
156.00 Subprovider - IPF		N	N		N	N	156.00
157.00 Subprovi der – IRF 158.00 SUBPROVI DER		N	N		Ν	N	157.00
158. 00 SUBPROVIDER 159. 00 SNF		Ν	N		Ν	N	158.00 159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more camp	uses in d	ifferent C	BSAs?	N	165.00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
1// 00/15 line 1/5 is was far each	0	1.00	2.00	3.00	4.00	5.00	1// 00
166.00 If line 165 is yes, for each campus enter the name in column						0.00	166.00
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)							
						1.00	
Health Information Technology (HI	() incentive in the Americ	an Recovery an	nd Reinves	tment Act		1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter "	Y" for yes or	"N" for n	D.		Y	167.00
168.00 If this provider is a CAH (line 10			e 167 is	"Y"), ente	r the		168.00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r			r gualifv	for a har	dshi n		168.01
exception under §413.70(a)(6)(ii)?	'Enter "Y" for yes or "N"	for no. (see	instructi	ons)	•		
169.00 If this provider is a meaningful utransition factor. (see instruction		is not a CAH	(line 105	is "N"),	enter the	0.00	169.00
	/// <i>3</i> /					I	I

Health Financial Systems	MARION GENERAL	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Period:	Worksheet S-2	
			From 07/01/2019		norod.
			lo 06/30/2020	Date/Time Pre 11/20/2020 1:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginner period respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans rep	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is yes, e	nter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet S- Part II Date/Time Pr 11/20/2020 1	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	N for all NO r	esponses. Ent	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.(
	reporting period? If yes, enter the date of the change in a	column 2. (see	instructions	s)		
			Y/N	Date	V/I	_
00	Use the provider terminated participation in the Medicara (Dragnom2 If	1.00 N	2.00	3.00	2.0
	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includir	nn 3, "V" for	Y N			3.0
00	contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board				5.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		N			5.
			1	Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider i	is N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 8.
00	Are costs claimed for Interns and Residents in an approved		cal education	n N		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	Ν		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an Ap	proved	N		11.
					Y/N 1.00	-
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	nstructions.	N	14.
	Did total beds available change from the prior cost reporti		yes, see ins t A	structions. Par	Y t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	09/29/2020	Y	09/29/2020	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.

10SPI T	Financial Systems MARION GENERA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0011	Peri od: From 07/01/2019 To 06/30/2020	u of Form CM Worksheet S Part II Date/Time P 11/20/2020	-2 repared:	
		Descr	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:			Ν	Ν	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)		1.00		
	Capital Related Cost		nosi i i i i i i i i i i i i i i i i i i				
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			ring the cost		23.00	
_0.00	reporting period? If yes, see instructions.		Sar S made du	ring the cost		20.00	
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost r	eporting period?		24.00	
	If yes, see instructions	5					
25.00	Have there been new capitalized leases entered into during	the cost repo	rting period	?lfyes, see		25.00	
	instructions.						
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	lfyes, see		26.00	
00 50	instructions.	o ooot	ng nor:10 !	fue out-t		1 27 00	
27.00	Has the provider's capitalization policy changed during th	e cost reporti	ng period? I	r yes, submit		27.00	
	copy. Interest Expense					-	
28 00	Were new Loans, mortgage agreements or letters of credit e	ntered into du	ring the cos	t reporting		28.00	
20.00	period? If yes, see instructions.		The cos	t reporting		20.00	
29.00							
	treated as a funded depreciation account? If yes, see inst			,		29.00	
30.00	Has existing debt been replaced prior to its scheduled mat		/debt?lfye	s, see		30.00	
	instructions.						
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	/debt?lfye	s, see		31.00	
	instructions.					_	
	Purchased Services	and and formal als					
32.00	Have changes or new agreements occurred in patient care se		ied through co	ontractual		32.00	
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to compet	itive bidding? If	,	33.00	
55.00	no, see instructions.		ing to competi	rive braaring: Ti		33.00	
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facility under an a	rrangement wit	h provider-b	ased physi ci ans?		34.00	
	If yes, see instructions.	5					
35.00	If line 34 is yes, were there new agreements or amended ex	isting agreeme	nts with the	provi der-based		35.00	
	physicians during the cost reporting period? If yes, see i	nstructions.					
				Y/N	Date		
				1.00	2.00		
04 00	Home Office Costs					2/ 00	
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	ronarod by the	home office	2		36.00 37.00	
57.00	If yes, see instructions.	repared by the	nome office	ſ		37.00	
38.00	If line 36 is yes, was the fiscal year end of the home of	fice different	from that o	f		38.00	
	the provider? If yes, enter in column 2 the fiscal year en					00.00	
39.00	If line 36 is yes, did the provider render services to oth			S,		39.00	
	see instructions.	F -	5				
40.00	If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00	
	instructions.						
					00		
	Cost Depart Droparan Contact Information	1.	. 00	2.	00		
	Cost Report Preparer Contact Information			SEVERS		41.00	
11 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ΤΙΝΑ		SEVERS		41.00	
41.00	The cost report preparer fir corumns r, z, allu s,						
41.00	respectively			1			
	respectively. Enter the employer/company name of the cost report	BLUE AND CO.	LLC			42.00	
		BLUE AND CO.,	LLC			42.00	
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., 317-713-7946	LLC	TSEVERS@BLUEAN	DCO. COM	42.00	

Heal th	Financial Systems MARION GEI	NERA	L HOSPI TAL	In Lie	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011	Period:	Worksheet S-2	2
				From 07/01/2019 To 06/30/2020) Date/Time Pre 11/20/2020 1:	epared: 17 pm
		Ļ				
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	Ν	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 cos	t				43.00
	report preparer in columns 1 and 2, respectively.					

AND HOSPITAL HEALTH CARE COMPLEX STATISTIC Component spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) D and other (see instructions) D IPF Subprovider D IPF Subprovider Spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT	Worksheet A Line Number 1.00	No. of Beds 2.00 87		Peri od: From 07/01/2019 To 06/30/2020 CAH Hours 4.00 2 0.00	Date/Time Pre 11/20/2020 1: I/P Days / O/P Visits / Trips Title V 5.00	pared: 17 pm 17 pm 1.00
spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	Line Number 1.00	2.00 87	Bed Days Avai I abl e 3.00	CAH Hours 4.00	11/20/2020 1: I/P Days / 0/P Visits / Trips Title V 5.00	17 pm 1.00
spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	Line Number 1.00	2.00 87	Avai I abl e 3. 00	4.00	I/P Days / O/P Visits / Trips Title V 5.00	1.00
spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	Line Number 1.00	2.00 87	Avai I abl e 3. 00	4.00	0/P Visits / Trips Title V 5.00	
spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	Line Number 1.00	2.00 87	Avai I abl e 3. 00	4.00	Trips Title V 5.00	
spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	Line Number 1.00	2.00 87	Avai I abl e 3. 00	4.00	Title V 5.00	
spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 0 and other (see instructions) 0 IPF Subprovider 0 IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	1.00	87	3.00			
exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider Spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)		87				
exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider Spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	30.00		31, 84	2 0.00	0	
spice days)(see instructions for col. 2 r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider O IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)						
r the portion of LDP room available beds) D and other (see instructions) D IPF Subprovider D IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)						
D and other (see instructions) D IPF Subprovider D IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)						
D IPF Subprovider D IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)						1 0 00
D IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)						2.00
spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)						4.00
spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)					0	•
tal Adults and Peds. (exclude observation ds) (see instructions)					0	
ds) (see instructions)		87	31, 84	2 0.00		
, , , , , , , , , , , , , , , , , , , ,		0,	01,01	2 0.00	Ű	/.00
	31.00	26	9, 51	6 0.00	0	8.00
RONARY CARE UNIT						9.00
RN INTENSIVE CARE UNIT						10.00
RGICAL INTENSIVE CARE UNIT						11.00
HER SPECIAL CARE (SPECIFY)						12.00
RSERY	43.00				0	13.00
tal (see instructions)		113	41, 35	8 0.00		
+ visits					0	
3PROVIDER - IPF	40.00	0		0	0	
3PROVIDER - IRF	41.00	18	6, 58		0	
	42.00	0		0	0	18.00
ILLED NURSING FACILITY RSING FACILITY						20.00
HER LONG TERM CARE						20.00
ME HEALTH AGENCY						21.00
BULATORY SURGICAL CENTER (D. P.)						23.00
SPICE						24.00
SPICE (non-distinct part)	30.00					24.10
HC - CMHC						25.00
RAL HEALTH CLINIC						26.00
DERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
tal (sum of lines 14-26)		131				27.00
servation Bed Days					0	
oul ance Trips						29.00
novee discount days (see instruction)						30.00
		_				31.00
oloyee discount days - IRF		0		U		32.00
oloyee discount days - IRF por & delivery days (see instructions)						32.01
oloyee discount days – IRF por & delivery days (see instructions) tal ancillary labor & delivery room				1		33.00
oloyee discount days - IRF por & delivery days (see instructions)						
DE ta se	ERALLY QUALIFIED HEALTH CENTER al (sum of lines 14-26) ervation Bed Days ulance Trips oyee discount days (see instruction) oyee discount days - IRF or & delivery days (see instructions)	ERALLY QUALIFIED HEALTH CENTER 89.00 al (sum of lines 14-26) ervation Bed Days Jlance Trips oyee discount days (see instruction) oyee discount days - IRF or & delivery days (see instructions) al ancillary labor & delivery room	ERALLY QUALIFIED HEALTH CENTER 89.00 al (sum of lines 14-26) 131 prvation Bed Days 131 ulance Trips oyee discount days (see instruction) oyee discount days - IRF 0 or & delivery days (see instructions) 0 al ancillary labor & delivery room 0	ERALLY QUALIFIED HEALTH CENTER 89.00 al (sum of lines 14-26) 131 ervation Bed Days 131 ulance Trips 131 oyee discount days (see instruction) 0 or & delivery days (see instructions) 0 al ancillary labor & delivery room 0	ERALLY QUALIFIED HEALTH CENTER 89.00 al (sum of lines 14-26) 131 ervation Bed Days 131 ulance Trips 0 oyee discount days (see instruction) 0 oyee discount days - IRF 0 or & delivery days (see instructions) 0 al ancillary labor & delivery room 0 oatient days (see instructions) 0	ERALLY QUALIFIED HEALTH CENTER89.000al (sum of lines 14-26)1310prvation Bed Days1310Jlance Trips00oyee discount days (see instruction)00oyee discount days - IRF00or & delivery days (see instructions)00al ancillary labor & delivery room00patient days (see instructions)00

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	MARION GENERAL AL DATA	Provider CC	CN: 15-0011	Period: From 07/01/2019	worksheet S-3 Part I	
					To 06/30/2020		
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		577	<u>8.00</u> 11,31		10.00	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	.,,	0.7	,			
2 00	for the portion of LDP room available beds)	2 2/1	2,010				2 00
2.00	HMO and other (see instructions)	3, 261	3, 910				2.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider	177	0 147				3.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	0	0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4, 589	577	11, 31	-		7.00
8.00	INTENSIVE CARE UNIT	851	0	3, 20)6		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	1, 61		000 50	13.00
14.00	Total (see instructions)	5, 440	577	16, 13		909.53	
15.00	CAH visits	0	0		0	0.00	15.00
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	0 2, 062	0 11	2,66	0 0.00 55 0.00		
17.00	SUBPROVIDER - TRF	2,002	0	2,00	0 0.00		
19.00	SKILLED NURSING FACILITY		0		0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			15	59		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	925.20	
28.00	Observation Bed Days		757	3, 25	52		28.00
29.00	Ambulance Trips	1, 244		4 6			29.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF			15	0		30.00
31.00	Labor & delivery days (see instructions)	0	0		0		31.00
32.00	Total ancillary labor & delivery room	U	0		0		32.00
52.01	outpatient days (see instructions)				Ĭ		32.01
33.00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	o					33.01

Full Time			To 06/30/2020	Date/Time Pre 11/20/2020 1:	
Equi val ents		Di sc	harges		
Nonpai d	Title V	Title XVIII	Title XIX	Total All	
				Patients	
					1.00
5)	000000000000000000000000000000000000000	76- 1, 51 20-	4 1, 133 0 13 1 146 0 0	4, 387 0 263 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 24.\ 00\\ 22.\ 00\\ 24.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 29.\ 00\\ 20.\ 00\\ 29.\ 00\\ 20.\ $
	Workers 11.00 and s) on 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Workers 11.00 12.00 ind 0 5) 0 0n 0.00 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0	Workers 11.00 12.00 13.00 ind 0 1,51* s) 76* inn 0 1,51* inn 0 1,51* inn 0.00 0 inn 0.00 0	Workers 11.00 12.00 13.00 14.00 and 0 1,511 146 s) 764 1,133 0 and 764 1,133 0 and 0 1,511 146 s) 764 1,133 0 and 0 0 13 0 and 0 0 0 0 and 0 0 0 13 and 0 0 0 0 and 0 0 0 0	Workers Patients 11.00 12.00 13.00 14.00 15.00 ind 0 1,511 146 4,387 s) 764 1,133 0 13 ind 0 1,511 146 4,387 ind 0 1,511 146 4,387 ind 0 0 13 0 ind 0 0 0 0 ind 0.00 0 0 0 ind 0 0 0 0

SPI T	AL WAGE INDEX INFORMATION			Provider C	F	eriod: rom 07/01/2019		
					Т	0 06/30/2020	Date/Time Pre 11/20/2020 1:	
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see instructions)	200.00	51, 467, 378	21, 999, 917	73, 467, 295	2, 162, 990. 00	33. 97	1
00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2
00	Non-physician anesthetist Part		0	0	0	0.00	0.00	:
00	B Physician-Part A -		557, 125	0	557, 125	3, 136. 00	177.65	4
)1	Administrative Physicians - Part A - Teaching		0	0			0.00	
00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6
00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	
D1	Contracted interns and residents (in an approved programs)		0	0	0	0. 00	0.00	7
00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8
00 00	SNF Excluded area salaries (see	44.00	0 9, 587, 957	0 14, 194, 999	0 23, 782, 956	0. 00 661, 226. 00	0.00 35.97	
00	instructions) OTHER WAGES & RELATED COSTS		7, 307, 737	14, 174, 777	23,702,730	001, 220. 00	55. 77	
00	Contract Labor: Direct Patient		5, 109, 998	0	5, 109, 998	96, 510. 00	52.95	1
00	Care Contract Labor: Top Level management and other management and administrative		0	0	0	0.00	0.00	1:
00	services Contract Labor: Physician-Part		191, 363	0	191, 363	1, 132. 00	169.05	1:
00	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0.00	14
01	wage-related costs Home office salaries		0	0	0	0.00	0.00	14
02	Related organization salaries		0	0	0		0.00	
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	1!
00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	10
01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	1
02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0.00	10
00	Wage-related costs (core) (see		14, 163, 506	0	14, 163, 506			11
00	instructions) Wage-related costs (other)							18
00	(see instructions) Excluded areas		7, 449, 459	0	7, 449, 459			10
00	Non-physician anesthetist Part A Non-physician anesthetist Part		0	0	0			20 2
00	B Physician Part A -		114, 423	0	114, 423			22
01	Administrative Physician Part A - Teaching		Ο	n	 			22
00	Physician Part B		0	0	0			23
00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0				24
50	approved program) Home office wage-related		0					2
50	(core) Related organization		0	0				25
	wage-related (core)		0					
52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25

Heal th	Financial Systems		MARION GENERA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part II	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6, 00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARI		0	0		0		25.53
26.00	Employee Benefits Department	4.00	1,009,337	39, 567	1, 048, 90	31, 444, 00	33.36	26.00
20.00	Administrative & General	5.00	11, 270, 831					
28.00	Administrative & General under		1, 454, 245		1, 454, 24			
20.00	contract (see inst.)		1, 434, 243	0	1, 101, 21	10,000.00	133.03	20.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	769, 765	0	769, 76			30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeepi ng	9.00	0	0		0 0.00		
33.00	Housekeeping under contract		1, 292, 045	0	1, 292, 04			
34.00	(see instructions) Dietary	10.00	19, 193	0	19, 19	3 314.00	41 10	34.00
34.00	Dietary under contract (see	10.00	307, 734		307, 73			
35.00	instructions)		307,734	0	307,73	17, 722.00	15.45	35.00
36.00	Cafeteri a	11.00	0	0		0 0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		
38.00	Nursing Administration	13.00	1, 203, 959	-365,920	838, 03			
39.00	Central Services and Supply	14.00	153, 997	7,639				
40.00	Pharmacy	15.00	2, 626, 099		2, 626, 09			
41.00	Medical Records & Medical	16.00	2, 020, 077	0	2,020,07	0 0.00		41.00
	Records Library	. 5. 66	0			0.00	5.00	
42.00	Social Service	17.00	0	0		0 0.00	0.00	42.00
	Other General Service	18.00	0	0		0 0.00		43.00
				•	•	1		•

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2019 To 06/30/2020		pared:	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average		
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage		
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷		
				(from	3)	col. 4	col. 5)		
				Worksheet					
				A-6)					
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		54, 521, 402	21, 999, 917	76, 521, 31	9 2, 293, 039. 00	33. 37	1.00	
	instructions)								
2.00	Excluded area salaries (see		9, 587, 957	14, 194, 999	23, 782, 95	6 661, 226. 00	35.97	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		44, 933, 445	7, 804, 918	52, 738, 36	3 1, 631, 813. 00	32.32	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		5, 301, 361	0	5, 301, 36	1 97, 642. 00	54.29	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		14, 277, 929	0	14, 277, 92	9 0.00	27.07	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		64, 512, 735	7, 804, 918	72, 317, 65	3 1, 729, 455. 00	41.82	6.00	
7.00	Total overhead cost (see		20, 107, 205	3, 220, 441	23, 327, 64	6 670, 955. 00	34.77	7.00	
	instructions)								
		·					I		

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provi der	CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020		pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					1, 318, 813	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	ution				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i					3, 570, 571	3.00
4.00	Qualified Defined Benefit Plan Cost (see inst	tructions)				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External C	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	า				1, 772, 907	6.00
7.00	Employee Managed Care Program Administration	Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					0	8.00
8.01	Health Insurance (Self Funded without a Third		0	8.01			
8.02	2 Health Insurance (Self Funded with a Third Party Administrator)						8.02
8.03	Health Insurance (Purchased)					0	8.03
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					0	10.00
11.00	Life Insurance (If employee is owner or benef	fi ci ary)				52, 140	11.00
12.00	Accident Insurance (If employee is owner or b	peneficiary)				0	12.00
13.00	Disability Insurance (If employee is owner or	r beneficiary)				354, 298	13.00
14.00	Long-Term Care Insurance (If employee is owned	er or beneficiar	y)			0	14.00
15.00	'Workers' Compensation Insurance					337, 762	15.00
16.00	Retirement Health Care Cost (Only current yea	ar, not the extra	aordinary a	accrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)		-		-		
	TAXES						
17.00	FICA-Employers Portion Only					4, 741, 738	
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					18, 174	19.00
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than F instructions))	Retirement Cost I	Reported or	n lines 1 thro	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					257, 913	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)					21, 727, 830	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Health Financial Systems	MARI ON GENERAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0011	Period: From 07/01/2019	Worksheet S-3 Part V	
		To 06/30/2020	Date/Time Pre 11/20/2020 1:	
Cost Center Description		Contract	Benefit Cost	
		Labor 1,00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Id	enti fi cati on:			
1.00 Total facility's contract labor and bene	fit cost	5, 109, 998	21, 727, 830	1.00
2.00 Hospi tal		5, 109, 998	21, 727, 830	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 GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0011	Period: From 07/01/2019	Worksheet S-1	0
				To 06/30/2020	Date/Time Pre 11/20/2020 1:	
					1.00	
	Uncompensated and indigent care cost computation	-			1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column	3 divided by I	ine 202 colum	n 8)	0. 254891	1.00
	Medicaid (see instructions for each line)	4		•		
2.00	Net revenue from Medicaid				17, 656, 746	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid					3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppl			ai d?		4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental paymen Medicaid charges	its from medica	i u		0 85, 001, 555	5.00 6.00
7.00	Medicaid cost (line 1 times line 6)				21, 666, 131	7.00
8.00	Difference between net revenue and costs for Medicaid prog	ram (line 7 mi	nus sum of li	nes 2 and 5: if	4, 009, 385	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructio	ns for each li	ne)			
9.00	Net revenue from stand-alone CHIP				0	
10.00	Stand-alone CHIP charges				0	10.00
11.00 12.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone C	HID (line 11 m	inus lino 0.	if < zero then	0	11.00
12.00	enter zero)		inus inne 9,	II < Zero then	0	12.00
	Other state or local government indigent care program (see	instructions ·	for each line)		1
13.00	Net revenue from state or local indigent care program (Not				0	
14.00	Charges for patients covered under state or local indigent	care program	(Not included	in lines 6 or	0	14.00
15 00	10) State on local indigent care program cost (line 1 times li	no 14)			0	15 00
15.00 16.00	State or local indigent care program cost (line 1 times li Difference between net revenue and costs for state or loca		o program (Li	no 15 minus line	-	15.00 16.00
10.00	13; if < zero then enter zero)	i indigent car			. 0	10.00
	Grants, donations and total unreimbursed cost for Medicaid	, CHIP and sta	te/local indi	gent care progra	ms (see	
	instructions for each line)					
17.00	Private grants, donations, or endowment income restricted				0	
18.00 19.00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and			s (sum of lines	0 4, 009, 385	18.00 19.00
19.00	8, 12 and 16)	rocar rhargent		S (Sum Of Trifes	4,007,303	19.00
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	pati ents	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entir	e facility	13, 756, 68	4, 894, 920	18, 651, 608	20.00
	(see instructions)	-				
21.00	Cost of patients approved for charity care and uninsured d	iscounts (see	3, 506, 45	4, 894, 920	8, 401, 376	21.00
22.00	instructions) Payments received from patients for amounts previously wri	tten off as	1	18 2, 831	3, 279	22.00
22.00	charity care	tten on as	4.	2,031	5,217	22.00
23.00	Cost of charity care (line 21 minus line 22)		3, 506, 00	4, 892, 089	8, 398, 097	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for p	ationt dave bo	word a Longth	of ctoy limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent		yonu a rengti	of Stay finit	IN	24.00
25.00	If line 24 is yes, enter the charges for patient days beyo		t care progra	m's length of	0	25.00
	stay limit	Ū.		Ū.		
26.00	Total bad debt expense for the entire hospital complex (se				11, 507, 888	
27.00	Medicare reimbursable bad debts for the entire hospital co				488, 457	1
27.01	Medicare allowable bad debts for the entire hospital compl	ex (see instru	CTIONS)		751, 472	1
28.00	Non-Medicare bad debt expense (see instructions)	±	1	`	10, 756, 416	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad deb		INSTRUCTIONS)	3,004,729	
30.00 31.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 pl				11, 402, 826 15, 412, 211	
51.00		us rine suj			1, 13, 412, 211	1 51.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARION GENERA	L HOSPITAL Provider CO	CN: 15-0011 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
				Fi Te	rom 07/01/2019 06/30/2020	Date/Time Pre 11/20/2020 1:	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	1 000 227	13, 201, 863		-1,062,234	12, 139, 629	1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 009, 337 11, 270, 831	18, 351, 555 29, 019, 117	19, 360, 892 40, 289, 948	39, 567 301, 152	19, 400, 459 40, 591, 100	4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	29,019,117	40, 209, 940	0	40, 391, 100	
6.01	00601 CAFETERI A	0	0	0	1, 425, 589	1, 425, 589	6.01
6.02	00602 CAFETERI A	0	0	0	0	0	6.02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	769, 765	4, 426, 565	5, 196, 330	466, 569 294, 553	5, 662, 899 294, 553	7.00 8.00
8.00 9.00	00900 HOUSEKEEPING	0	2,907,519	2, 907, 519	-285, 673	2, 621, 846	
10.00	01000 DI ETARY	19, 193	1, 954, 161	1, 973, 354	-1, 456, 958	516, 396	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 203, 959	70, 422	1, 274, 381	-364, 354	910, 027	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	153, 997	310, 439	464, 436	9, 153	473, 589	
15.00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 626, 099	11, 212, 684	13, 838, 783	-10, 259, 314	3, 579, 469	15.00
30.00	03000 ADULTS & PEDI ATRI CS	6, 590, 779	1, 316, 384	7, 907, 163	-982, 247	6, 924, 916	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 794, 784	511, 398	2, 306, 182	-39, 567	2, 266, 615	31.00
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	976, 301 0	857, 369 0	1, 833, 670 0	0	1, 833, 670 0	
42.00	04300 NURSERY	0	0	0	1, 234, 585	1, 234, 585	42.00 43.00
	ANCILLARY SERVICE COST CENTERS		-	-	.,,	.,,	
50.00	05000 OPERATING ROOM	1, 164, 752	10, 111, 400	11, 276, 152	152, 246	11, 428, 398	50.00
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 3, 048, 589	0 2, 809, 250	0 5, 857, 839	0 -959, 524	0 4, 898, 315	51.00 54.00
57.00	05700 CT SCAN	3, 048, 589	2, 809, 230	5, 057, 059	910, 635	4, 898, 315 910, 635	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	480, 243	480, 243	
59.00	05900 CARDI AC CATHETERI ZATI ON	620, 318	1, 422, 479	2, 042, 797	28, 840	2,071,637	59.00
60.00	06000 LABORATORY	2, 287, 167	5, 838, 148	8, 125, 315	2, 993	8, 128, 308	
60. 01 60. 02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	1, 016, 265	638, 328 0	1, 654, 593 0	0	1, 654, 593 0	60. 01 60. 02
65.00	06500 RESPIRATORY THERAPY	1, 404, 447	764, 876	2, 169, 323	0	2, 169, 323	65.00
66.00	06600 PHYSI CAL THERAPY	1, 843, 588	318, 167	2, 161, 755	179	2, 161, 934	66.00
69.00	06900 ELECTROCARDI OLOGY	772, 698	203, 901	976, 599	70, 389	1, 046, 988	
69. 01 71. 00	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	141, 019 0	30, 343 0	171, 362 0	41, 830 0	213, 192 0	69.01 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	10, 259, 314	10, 259, 314	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	292, 774	695, 570	988, 344	49, 065	1,037,409	90.00
	09100 EMERGENCY	3, 849, 060	7, 109, 340	988, 344 10, 958, 400	-54, 826	10, 903, 574	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1, 038, 293	172, 853	1, 211, 146	26, 239	1, 237, 385	95.00
70.00	SPECIAL PURPOSE COST CENTERS	1,000,270	172,000	1,211,110	20, 20,	1,207,000	70.00
	11300 INTEREST EXPENSE		0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	43, 894, 015	114, 254, 131	158, 148, 146	328, 444	158, 476, 590	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 172	13, 172	28, 422	41, 594	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
	19201 PACT REV PHYSICIANS	103, 646	898, 253	1, 001, 899	-370, 001	631, 898	
	19202 VI SI TOR MEALS 19203 GREAT BEGI NNI NGS/MATERNAL	0 88, 667	0 4, 348	0 93, 015	0 11, 076	0 104, 091	192.02
	19204 LI FELI NE	00,007	4, 540	93, 015	0		192.03
	19205 OWNED PROPERTIES	0	1, 396, 029	1, 396, 029	-1, 060, 872	335, 157	
	19206 UROLOGY	352, 430	911, 968	1, 264, 398	37, 059	1, 301, 457	
	19207 PHYSI CLANS' PRI VATE OFFI CES 19211 PARI SH NURSI NG	0 57, 507	0 13, 921	0 71, 428	0 3, 428	0 74, 856	192.07
	19212 BI OTERRORI SM GRANT	0	0	0	0, 420		192.00
192.10	19214 BREAST PUMPS	0	0	0	О	0	192.10
	19208 MGH EMERGENCY PHYSICIANS 19209 LUNG CENTER	0 128, 125	0 682, 670	0 810, 795	0 25, 473	0 836, 268	192.11
	19213 MGH EXPRESS	521, 625	748, 918	1, 270, 543	43, 943	830, 208 1, 314, 486	
	19210 MGH PHYS PRACT MGMT	1, 138, 540	728, 830	1, 867, 370	37, 995	1, 905, 365	
	19215 MGH MARI ON SURGEONS	447, 141	1, 563, 917	2, 011, 058	65, 399	2, 076, 457	192.15
	19216 MGH MGH MED ONC	0	1, 417, 992	1, 417, 992	0	1, 417, 992	
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	802, 146 130, 866	1, 822, 510 371, 933	2, 624, 656 502, 799	371, 796 41, 421	2, 996, 452 544, 220	
	19219 MGH FMC MARION	282, 770	574, 039	856, 809	34, 220	891, 029	
	19300 NONPAI D WORKERS	0	0	0	0		193.00
193.01	19301 MGH FMC NORTHWOOD	320, 556	848, 893	1, 169, 449	658	1, 170, 107	1193.01

RECLASSI FI CATI ON AND ADJUSTMENTS OF TRI AL BALANCE OF EX Cost Center Description 193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH FMC GAS CITY 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDI ATRI C CTR 193. 07 19307 MGH SPECI ALTY PHYS 193. 08 19308 MGH FMC CONVERSE 193. 09 19309 MGH MGH WOMENS CTR 193. 11 19311 MGH MGH PSYCHIATRY 193. 12 19312 0B/GYN	1.00 220,016 -2,193 1,022,884 92,213 235,465 57,369 109,994	Provi der CC 0ther 2.00 622,700 3,690,743 2,096,493 164,304 815,585			Date/Time Pre 11/20/2020 1: Reclassified Trial Balance (col. 3 +- col. 4) 5.00 915,223	17 pm
193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH HOSPITALISTS 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDIATRIC CTR 193. 07 19307 MGH SPECIALTY PHYS 193. 08 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH 193. 10 19310 MGH MGH PSYCHIATRY	1.00 220,016 -2,193 1,022,884 92,213 235,465 57,369	2.00 622,700 3,690,743 2,096,493 164,304	Total (col. 7 + col. 2) 3.00 842, 71 3, 688, 55	To 06/30/2020 Reclassificat i ons (See A-6) 4.00 6 72,507	Date/Time Pre 11/20/2020 1: Reclassified Trial Balance (col. 3 +- col. 4) 5.00 915,223	17 pm
193. 02 19302 MGH FMC GAS CITY 193. 03 19303 MGH HOSPITALISTS 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDIATRIC CTR 193. 07 19307 MGH SPECIALTY PHYS 193. 08 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH 193. 10 19310 MGH MGH PSYCHIATRY	1.00 220,016 -2,193 1,022,884 92,213 235,465 57,369	2.00 622,700 3,690,743 2,096,493 164,304	+ col. 2) 3.00 842,71 3,688,55	i ons (See A-6) 4.00 6 72,507	Tri al Bal ance (col. 3 +- col. 4) 5.00 915,223	
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT 193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDIATRIC CTR 193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH SCTR 193.11 19311 MGH MGH PSYCHIATRY	220, 016 -2, 193 1, 022, 884 92, 213 235, 465 57, 369	622, 700 3, 690, 743 2, 096, 493 164, 304	3.00 842,71 3,688,55	A-6) 4.00 6 72,507	(col. 3 +- col. 4) 5.00 915,223	
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT 193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDIATRIC CTR 193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH SCTR 193.11 19311 MGH MGH PSYCHIATRY	220, 016 -2, 193 1, 022, 884 92, 213 235, 465 57, 369	622, 700 3, 690, 743 2, 096, 493 164, 304	842, 71 3, 688, 55	4.00 6 72,507	col . 4) 5.00 915,223	
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT 193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDIATRIC CTR 193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH SCTR 193.11 19311 MGH MGH PSYCHIATRY	220, 016 -2, 193 1, 022, 884 92, 213 235, 465 57, 369	622, 700 3, 690, 743 2, 096, 493 164, 304	842, 71 3, 688, 55	6 72, 507	5.00 915,223	
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT 193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDIATRIC CTR 193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH SCTR 193.11 19311 MGH MGH PSYCHIATRY	220, 016 -2, 193 1, 022, 884 92, 213 235, 465 57, 369	622, 700 3, 690, 743 2, 096, 493 164, 304	842, 71 3, 688, 55	6 72, 507	915, 223	
193.03 19303 MGH HOSPITALISTS 193.04 19304 MGH MAR FAM PRACT 193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDIATRIC CTR 193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH SCTR 193.11 19311 MGH MGH PSYCHIATRY	-2, 193 1, 022, 884 92, 213 235, 465 57, 369	3, 690, 743 2, 096, 493 164, 304	3, 688, 55			
193.04 19304 MGH MAR FAM PRACT 193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDI ATRI C CTR 193.07 19307 MGH SPECI ALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH SCTR 193.11 19311 MGH MGH PSYCHI ATRY	1, 022, 884 92, 213 235, 465 57, 369	2, 096, 493 164, 304		0 0		
193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDI ATRI C CTR 193.07 19307 MGH SPECI ALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH SCTR 193.11 19311 MGH MGH PSYCHI ATRY	92, 213 235, 465 57, 369	164, 304	3, 119, 37		-,,	
193.06 19306 MGH PEDI ATRI C CTR 193.07 19307 MGH SPECI ALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH WOMENS CTR 193.11 19311 MGH MGH PSYCHI ATRY	235, 465 57, 369			7 0	3, 119, 377	193.04
193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH WOMENS CTR 193.11 19311 MGH MGH PSYCHIATRY	57, 369	815, 585	256, 51	7 27, 449	283, 966	193.05
193.08 19308 MGH FMC CONVERSE 193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH WOMENS CTR 193.11 19311 MGH MGH PSYCHIATRY			1, 051, 05	0 52, 141	1, 103, 191	193.06
193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH WOMENS CTR 193.11 19311 MGH MGH PSYCHIATRY	109, 994	243, 537	300, 90	6 12, 559	313, 465	193.07
193.1019310 MGH MGH WOMENS CTR 193.1119311 MGH MGH PSYCHLATRY		238, 248	348, 24	2 307	348, 549	193.08
193. 11 19311 MGH MGH PSYCHLATRY	483, 933	1, 235, 646	1, 719, 57		1, 723, 291	193.09
	0	0		0 0		193.10
	0	0		0 0	0	193.11
	563, 937	2, 318, 472	2, 882, 40	9 10, 701		
193. 15 19315 MGH RIVER VIEW BLDG	000, 101	2,010,112	2/002/10	0 0		193.15
193. 16 19316 MGH NEONATOLOGY	0	889, 400	889, 40	0	889, 400	
193. 18 19318 MGH WOUND CARE	0	24, 160	24, 16		24, 160	
194. 00 07963 HEART FAILURE CLINIC	0	51,647	51,64		51, 647	
194. 01 07950 MOW	0	01,047		0 0		194.00
194. 02 07951 MENTAL HEALTH	0	0				194.01
194. 03 07952 ADVERTI SI NG	0	0		0 218, 861		
194. 04 07953 MGH WORK SOLUTIONS	274, 835	647, 500	922, 33			
194. 05 07954 MGH TAYLOR UNIVERSITY	19, 886	90, 866	922, 33 110, 75			
194. 06 07955 0PI 0I D I MPL GRANT						
	43, 432	169, 157	212, 58		212, 589	
194. 07 07956 ASTHMA GRANT	3, 115	1, 971	5, 08			194.07
194. 08 07957 MGH SMMP BLDG	0	0		0 0		194.08
194. 09 07958 MGH AMBUCARE BLDG	0	7 570		0 0		194.09
194.1007959 MGH 106 LYONS BLDG	0	7, 573	7, 57			194.10
194. 11 07960 FAI RMOUNT	0	0		0 0		194.11
194. 12 07961 GAS CI TY	0	0		0 C		194.12
194. 13 07969 LYONS	0	0		o 0		194.13
194. 14 07964 WABASH	0	0		0 0		194.14
194. 15 07965 TOBACCO GRANT	36, 658	16, 743	53, 40		53, 401	
194. 16 07966 HRSA NETWORK DEV PLANNING	1, 934	9, 176	11, 11		11, 110	
194.17 07967 HRSA OPIOLD PLANNING	13, 652	100, 043	113, 69	5 0	113, 695	194.17
194. 18 07962 ECHO GRANT	0	80	8		80	101 10
194. 19 07968 RURAL QI GRANT	22, 214	85, 294	107 50	1		194.18
200.00 TOTAL (SUM OF LINES 118 through 199) 5	51, 467, 378		107, 50	8 0		

		F EXPENSES		CN: 15-0011	Period: From 07/01/2019	Worksheet A
					To 06/30/2020	Date/Time Prepare 11/20/2020 1:17 p
	Cost Center Description	Adjustments (See A-8)	Net Expenses For			
		(300 A 0)	Allocation			
		6. 00	7.00			
00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	-84, 005	12,055,624			1.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 868, 907				4.
00	00500 ADMI NI STRATI VE & GENERAL	-17, 137, 044				5.
00	00600 MAI NTENANCE & REPAI RS	0	-			6.
01		-7,084				6.
02 00	00602 CAFETERIA 00700 OPERATION OF PLANT	-194, 095	0 5, 468, 804			6. 7.
00	00800 LAUNDRY & LINEN SERVICE	-4, 735				8.
00	00900 HOUSEKEEPI NG	-90	2, 621, 756			9.
		-171				10.
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0 -821				13.
	01500 PHARMACY	-29, 566				14.
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	-7,610				30.
	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	-794				31. 40.
	04100 SUBPROVIDER - IRF	-64, 799				40.
	04200 SUBPROVI DER	0				42.
8.00	04300 NURSERY	0	1, 234, 585			43.
). 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	-1, 204, 128	10, 224, 270			50.
	05100 RECOVERY ROOM	-1, 204, 128				51.
	05400 RADI OLOGY-DI AGNOSTI C	-172,037				54.
	05700 CT SCAN	0	, 10, 000			57.
	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0				58.
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	-46, 817 -85, 838				59. 60.
	06001 ONCOLOGY	-5, 178				60.
	06002 RADIATION ONCOLOGY	0				60.
	06500 RESPIRATORY THERAPY	-1, 345				65.
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	124- 54, 205-				66. 69.
	06901 CARDI AC REHAB	-166				69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	0				72.
	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	10, 259, 314			73.
	09000 CLINIC	-1, 108	1,036,301			90.
	09100 EMERGENCY	-5, 176, 089	5, 727, 485			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.
2.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0			92.
5.00	09500 AMBULANCE SERVICES	-64, 112	1, 173, 273			95.
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE	0				113.
8.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-27, 210, 868	131, 265, 722			118.
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41, 594			190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	°			192.
	19201 PACT REV PHYSI CLANS	0	631, 898			192.
	19202 VI SI TOR MEALS 19203 GREAT BEGI NNI NGS/MATERNAL	0	104, 091			192. 192.
	19204 LI FELI NE	0	0			192.
	19205 OWNED PROPERTIES	0	0007.107			192.
		-60, 182	1, 241, 275			192.
	19207 PHYSICIANS' PRIVATE OFFICES 19211 PARISH NURSING	0	0 74, 856			192. 192.
	19212 BI OTERRORI SM GRANT	0	, , , 050			192.
2. 10	19214 BREAST PUMPS	0	0			192.
	19208 MGH EMERGENCY PHYSI CLANS	0	0			192.
	19209 LUNG CENTER 19213 MGH EXPRESS	-49, 272	786, 996 1, 314, 486			192. 192.
	19213 MGH PHYS PRACT MGMT	-65, 159				192.
	19215 MGH MARI ON SURGEONS	-115, 214				192.
	19216 MGH MGH MED ONC	0	.,,=			192.
	19217 MGH FMC SOUTH	-345, 266				192.
	19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION	-27, 662 -62, 692				192. 192.
2.19		52,072	1 020,007			[' ⁷ - .
	19300 NONPALD WORKERS	0	0			193.

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lieu	u of Form CMS-2552-
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C	CN: 15-0011	Period:	Worksheet A
				From 07/01/2019 To 06/30/2020	Date/Time Prepared
				10 00/ 30/ 2020	11/20/2020 1:17 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
		Allocation	-		
	6.00	7.00			
193. 03 19303 MGH HOSPI TALI STS	0	0,000,000	•		193. (
193. 04 19304 MGH MAR FAM PRACT	0	-,,			193. (
193.05 19305 MGH FMC SWAYZEE	-26, 352				193. (
193. 06 19306 MGH PEDIATRIC CTR	-67, 608		•		193. (
193.07 19307 MGH SPECIALTY PHYS	-25, 340				193. (
193.08 19308 MGH FMC CONVERSE	0		1		193. (
193.0919309 MGH UPLAND HEALTH	0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		193. (
193. 10 19310 MGH MGH WOMENS CTR	0	0			193. 1
193. 11 19311 MGH MGH PSYCHIATRY	0	0			193. 1
193. 12 19312 OB/GYN	0	2, 893, 110	1		193.1
193. 15 19315 MGH RIVER VIEW BLDG	0	0			193. 1
193. 16 19316 MGH NEONATOLOGY	0	889, 400			193. 1
193. 18 19318 MGH WOUND CARE	0	24, 160			193.
194. 00 07963 HEART FAILURE CLINIC	0	51, 647			194. (
194. 01 07950 MOW	0	0			194. (
194. 02 07951 MENTAL HEALTH	0	0			194. (
194. 03 07952 ADVERTI SI NG	0	218, 861			194. (
194. 04 07953 MGH WORK SOLUTIONS	-36, 975				194. (
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	110, 752			194. (
194. 06 07955 OPI OI D I MPL GRANT	0	212, 589			194. (
194. 07 07956 ASTHMA GRANT	0	5, 086			194. (
194. 08 07957 MGH SMMP BLDG	0	0	•		194. (
194. 09 07958 MGH AMBUCARE BLDG	0	0	1		194. (
194. 10 07959 MGH 106 LYONS BLDG	0	7, 573	1		194.1
194. 11 07960 FAI RMOUNT	0	0	•		194.1
194. 12 07961 GAS CI TY	0	0			194.1
194. 13 07969 LYONS	0	0			194.1
194. 14 07964 WABASH	0	0			194.1
194. 15 07965 TOBACCO GRANT	0	53, 401	1		194.1
194. 16 07966 HRSA NETWORK DEV PLANNING	0	11, 110			194. 1
194. 17 07967 HRSA OPI OI D PLANNI NG	0	113, 695			194.1
194. 18 07962 ECHO GRANT	0	80			194.1
194. 19 07968 RURAL QI GRANT		107, 508	1		194.1
200.00 TOTAL (SUM OF LINES 118 through 199)	-28, 240, 376	162, 997, 864	I		200.0

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Lieu o	of Form CMS-2552-10
	SI FI CATI ONS			Provider (CCN: 15-0011		orksheet A-6
							ate/Time Prepared:
		Increases				1	1/20/2020 1:17 pm
	Cost Center	Li ne #	Sal ary	Other			
	2.00	3.00	4.00	5.00			
1 00	A - SATELLITE OFFICE	(0.00)	0.000	0.507			1.00
1.00 2.00	ELECTROCARDI OLOGY RADI OLOGY-DI AGNOSTI C	69.00 54.00	9, 238 55, 152	3, 507 5, 722			1.00
3.00	PHYSI CAL THERAPY	66.00	142	37			3.00
	TOTALS		64, 532	9, 266			
1 00	B - CAFETERIA	F 00			1		1.00
1.00 2.00	ADMI NI STRATI VE & GENERAL CAFETERI A	5. 00 6. 01	0	57, 544 1, 425, 589			1.00
2.00	TOTALS	0.01	— — — o	1, 483, 133			2.00
	C - ADMIN DIRECTOR				I		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	39, 567	0			1.00
2.00 3.00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14.00 30.00	9, 153 252, 338	0 0			2.00
4.00	CARDI AC CATHETERI ZATI ON	59.00	232, 338	0			4.00
5.00	ELECTROCARDI OLOGY	69.00	43, 260	0			5.00
6.00	CARDI AC REHAB	69.01	28, 840	0			6.00
7.00	AMBULANCE SERVICES	95.00	26, 239	0			7.00
8.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	28, 422	0			8.00
9.00	GREAT BEGI NNI NGS/MATERNAL	192. 03	11, 076	0			9.00
10.00	MGH EXPRESS	1 <u>92.</u> 13	28, 587	0			10.00
			496, 322	0			
1.00	D - ADVERTI SI NG ADVERTI SI NG	194.03	111, 868	106, 993			1.00
1.00	TOTALS	1 <u>94.03</u>	111,868	106, 993			1.00
	E - LEASED PROPERTY		,	,			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	114, 607			1.00
2.00	OPERATION OF PLANT	7.00	0	464, 977			2.00
3.00 4.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0 0	8, 529 25, 585			3.00
4.00 5.00	OPERATI NG ROOM	50.00	0	152, 246			5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	299, 998			6.00
7.00	CT SCAN	57.00	0	21, 337			7.00
8.00	MAGNETIC RESONANCE IMAGING	58.00	0	24, 062			8.00
9.00	(MRI) LABORATORY	60.00	o	74, 045			9.00
10.00	ELECTROCARDI OLOGY	69.00	0	14, 384			10.00
11.00	CARDI AC REHAB	69.01	0	12, 990			11.00
12.00		90.00	0	49,065			12.00
13.00 14.00	PARI SH NURSI NG LUNG CENTER	192.08 192.12	0	3, 428 25, 473			13.00 14.00
15.00	MGH EXPRESS	192.12	0	15, 356			15.00
16.00	MGH PHYS PRACT MGMT	192.14	0	37, 995			16.00
17.00	MGH MARION SURGEONS	192.15	0	65, 399			17.00
18.00	MGH FMC SOUTH	192.17	0	347, 308			18.00
19.00 20.00	MGH FAIRM MED ASSOC MGH FMC MARION	192. 18 192. 19	0	41, 421 34, 220			19.00 20.00
21.00	MGH WORK SOLUTIONS	194.04	0	3, 302			21.00
22.00	UROLOGY	192.06	0	37, 059			22.00
23.00	MGH FMC NORTHWOOD	193.01	0	658			23.00
24.00 25.00	MGH FMC GAS CITY MGH FMC SWAYZEE	193. 02 193. 05	0	72, 507			24.00 25.00
25.00 26.00	MGH FMC SWAYZEE MGH PEDIATRIC CTR	193.05 193.06	0	27, 449 52, 141			25.00
27.00	MGH SPECIALTY PHYS	193.07	Ő	12, 559			27.00
28.00	MGH FMC CONVERSE	193.08	0	307			28.00
29.00	MGH UPLAND HEALTH	193.09	0	3, 712			29.00
30.00	OB/GYN	<u> </u>	0	1 <u>0, 701</u> 2, 052, 820			30.00
	F - PHARMACY RECLASS		J	2,052,620	I		
1.00	DRUGS_CHARGED_TO_PATIENTS	73.00	0	<u>10, 259, 3</u> 14			1.00
	TOTALS		0	10, 259, 314			
1 00	G - CT/MRI RECLASS CT SCAN	57.00	161 EEO	100 000			1.00
1.00 2.00	MAGNETIC RESONANCE IMAGING	57.00	464, 550 237, 810	423, 223 216, 654			1.00
2.00	(MRI)						2.00
	TOTALS		702, 360	639, 877]		
1 00	H - SHORT TERM DI SABI LI TY	10.00		4 544			
1.00 2.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	1, 566 1, 514			1.00
2.00 3.00	ADULTS & PEDIATRICS	30.00	0	7, 008			3.00
4.00	CARDI AC CATHETERI ZATI ON	59.00	0	14, 866			4.00
5.00	ELECTROCARDI OLOGY	69.00	0	234			5.00
6.00	EMERGENCY	<u> </u>	•	<u>2, 197</u>			6.00
	TOTALS		o	27, 385			

Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	S

MARION GENERAL HOSPITAL

Provider CCN: 15-0011

In Lieu of Form CMS-2552-10

 Period:
 Worksheet A-6

 From 07/01/2019
 Date/Time Prepared

 To
 06/30/2020
 Date/Time Prepared

					20 1:17 pm
		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	I - NURSERY RECLASS				
1.00	NURSERY	43.00	1,033,128	201, 457	1.00
	TOTALS		1,033,128	201, 457	
	J - SMMP HOUSEKEEPING RECLASS	5	· · · ·	· · ·	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	15, 436	1.00
2.00	OPERATION OF PLANT	7.00	0	1, 592	2.00
3.00	HOUSEKEEPI NG	9.00	0	351	3.00
4.00	DI ETARY	10.00	0	590	4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	21, 841	5.00
6.00	CT SCAN	57.00	0	1, 525	6.00
7.00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 717	7.00
	(MRI)				
8.00	LABORATORY	60.00	0	2, 746	8.00
9.00	MGH FMC SOUTH	192.17	0	24, 488	9.00
	TOTALS	T	0	70, 286	
	K - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	294, 553	1.00
	TOTALS			294, 553	
	L - PHYSICIAN MEDICAL DIRECTO)R		· · ·	
1.00	ADMI NI STRATI VE & GENERAL	5.00	370, 001	0	1.00
	TOTALS	+	370,001	— — — <u>0</u>	
	M - PHYSICIAN SALARY RECLASS		· · ·		
1.00	ADMI NI STRATI VE & GENERAL	5.00	3, 318, 597	0	1.00
2.00	SUBPROVI DER – I RF	41.00	54,800	0	2.00
3.00	RESPI RATORY THERAPY	65.00	5, 450	0	3.00
4.00	PHYSI CAL THERAPY	66.00	3,067	0	4.00
5.00	CARDI AC REHAB	69.01	16, 193	0	5.00
7.00	EMERGENCY	91.00	4, 325, 187	0	7.00
8.00	PACT REV PHYSI CLANS	192.01	718, 291	0	8.00
9.00	UROLOGY	192.06	501, 743	0	9,00
10.00	LUNG CENTER	192.12	500, 899	0	10.00
11.00	MGH EXPRESS	192.13	393, 631	0	11.00
12.00	MGH MARI ON SURGEONS	192.15	1, 142, 893	0	12.00
13.00	MGH MGH MED ONC	192.16	1, 155, 509	0	13.00
14.00	MGH FMC SOUTH	192.17	1,027,933	0	14.00
15.00	MGH FAIRM MED ASSOC	192.18	183, 424	0	15.00
16.00	MGH FMC MARION	192.19	355, 231	0	16.00
17.00	MGH FMC NORTHWOOD	193.01	580, 113	0	17.00
18.00	MGH FMC GAS CITY	193.02	294, 627	0	18.00
19.00	MGH HOSPI TALI STS	193.03	2, 995, 774	0	19.00
20.00	MGH MAR FAM PRACT	193.04	1, 254, 344	0	20.00
21.00	MGH FMC SWAYZEE	193.05	84, 615	0	21.00
22.00	MGH PEDIATRIC CTR	193.06	431, 794	0	22.00
23.00	MGH SPECIALTY PHYS	193.07	163, 337	Ő	23.00
24.00	MGH FMC CONVERSE	193.08	103, 569	Ő	24.00
25.00	MGH UPLAND HEALTH	193.09	634, 161	0	25.00
26.00	OB/GYN	193.12	1, 411, 772	0	26.00
27.00	MGH WOUND CARE	193.18	19, 758	0	27.00
28.00	HEART FAILURE CLINIC	194.00	33, 037	0	28.00
29.00	MGH WORK SOLUTIONS	194.04	246, 613	0	29.00
30.00	MGH TAYLOR UNI VERSI TY	194.05	70, 940	0	30.00
00.00	TOTALS		22, 027, 302	— — <u> </u>	30.00
500 00	Grand Total: Increases		24, 805, 513	15, 145, 084	500.00
000.00		I	_ ,, 000, 010		1000.00

Financial Systems SIFICATIONS		MARION GENERAL	HOSPITAL		eu of Form CMS-255 Worksheet A-6
				To 06/30/2020	
	Decreases			1	111/20/2020 111/
Cost Center	Line #	Salary		A-7 Ref.	
6.00 A - SATELLITE OFFICE	7.00	8.00	9.00	10.00	
LABORATORY	60.00	64, 532	9, 266	0	
	0.00	0	0	0	
	0.00	0	0	0	
TOTALS		64, 532	9, 266		
B – CAFETERIA DI ETARY	10.00	0	1, 483, 133	0	
	0.00	0	0	o	
TOTALS		0	1, 483, 133		
C – ADMIN DIRECTOR					
ADMI NI STRATI VE & GENERAL NURSI NG ADMI NI STRATI ON	5.00 13.00	37, 575 364, 354	0	0	
INTENSIVE CARE UNIT	31.00	364, 354	0	0	
EMERGENCY	91.00	54, 826	0	o	
	0.00	0	0	0	
	0.00	0	0	0	
	0.00	0	0	0	
	0.00	0	0	0	
	0.00 0.00	0	0	0	1
TOTALS		496, 322		— — ⁴	
D - ADVERTI SI NG					
ADMI NI STRATI VE & GENERAL	5.00	11 <u>1, 8</u> 68	10 <u>6, 9</u> 93	0	
TOTALS E - LEASED PROPERTY		111, 868	106, 993		
NEW CAP REL COSTS-BLDG &	1.00	0	1,062,234	10	
FIXT	1.00	0	1,002,234	10	
OWNED PROPERTIES	192.05	0	990, 586	0	
	0.00	0	0	0	
	0.00	0	0	0	
	0.00 0.00	0	0	0	
	0.00	0	0	0	
	0.00	0	0	o	
	0.00	0	0	o	
	0.00	0	0	o	1
	0.00	0	0	0	1
	0.00	0	0	0	1
	0. 00 0. 00	0	0	0	1
	0.00	0	0	o	1
	0.00	0	0	0	1
	0.00	0	0	0	1
	0.00	0	0	0	1
	0.00	0	0	0	1
	0.00	0	0	0	2
	0.00 0.00	0	0	0	2
	0.00	0	0	0	2
	0.00	o	0	o	2
	0.00	0	0	0	2
	0.00	0	0	0	2
	0.00	0	0	O	2
	0.00	0	0	0	2
	0.00	0	0	0	2
TOTALS		— — <u> </u>	2, 052, 820	— — ⁴	3
F - PHARMACY RECLASS			_, _ 52, 520		
PHARMACY		0	10, 259, 314	0	
		0	10, 259, 314		
G – CT/MRI RECLASS RADI OLOGY-DI AGNOSTI C	54.00	702, 360	639, 877	0	
	0.00	102, 300	037,077	0	
TOTALS		702, 360	639, 877	— — ĭ	
H - SHORT TERM DI SABI LI TY			1	1	
NURSING ADMINISTRATION	13.00	1, 566	0	0	
CENTRAL SERVICES & SUPPLY	14.00	1, 514	0	0	
ADULTS & PEDIATRICS CARDIAC CATHETERIZATION	30. 00 59. 00	7,008	0	0	
ELECTROCARDI OLOGY	59.00 69.00	14, 866 234	0	0	
EMERGENCY	91.00	2, 197	0	0	

	Financial Systems		MARION GENERA			In Lieu	of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-0011	Period:	Worksheet A-	-6
						From 07/01/2019 To 06/30/2020	Date/Time Pr	renared
							11/20/2020 1	
		Decreases			-	1		
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ret	F		
	6.00	7.00	8.00	9.00	10.00			
	I - NURSERY RECLASS				1	-1		
1.00	ADULTS & PEDIATRICS	<u>30.</u> 00	<u>1, 033, 1</u> 28	20 <u>1,4</u> 57		<u>o</u>		1.00
	TOTALS		1, 033, 128	201, 457				_
	J - SMMP HOUSEKEEPING RECLASS					-1		
1.00	OWNED PROPERTIES	192.05	0	70, 286		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	0	0		0		5.00
6.00		0.00	0	0		0		6.00
7.00		0.00	0	0		0		7.00
8.00		0.00	0	0		0		8.00
9.00		0.00	0	0		0		9.00
	TOTALS		0	70, 286				
	K – LAUNDRY RECLASS							
1.00	HOUSEKEEPING		0	29 <u>4,5</u> 53		0		1.00
	TOTALS		o	294, 553				
	L - PHYSICIAN MEDICAL DIRECTO)R						
1.00	PACT REV PHYSICIANS	192.01	370, 001	0		0		1.00
	TOTALS	+	370, 001	0		1		1
	M - PHYSICIAN SALARY RECLASS							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	3, 318, 597		0		1.00
2.00	SUBPROVI DER – I RF	41.00	0	54, 800		0		2.00
3.00	RESPI RATORY THERAPY	65.00	0	5, 450		0		3.00
4.00	PHYSI CAL THERAPY	66.00	0	3,067		0		4.00
5.00	CARDI AC REHAB	69.01	0	16, 193		0		5.00
7.00	EMERGENCY	91.00	0	4, 325, 187		0		7.00
8.00	PACT REV PHYSICIANS	192.01	0	718, 291		0		8.00
9.00	UROLOGY	192.06	o	501, 743		0		9.00
10.00	LUNG CENTER	192.12	0	500, 899		0		10.00
11.00	MGH EXPRESS	192. 13	0	393, 631		0		11.00
12.00	MGH MARION SURGEONS	192.15	0	1, 142, 893		0		12.00
13.00	MGH MGH MED ONC	192.16	0	1, 155, 509		0		13.00
14.00	MGH FMC SOUTH	192.17	0	1, 027, 933		0		14.00
15.00	MGH FAIRM MED ASSOC	192.18	0	183, 424		0		15.00
16.00	MGH FMC MARION	192.19	0	355, 231		0		16.00
17.00	MGH FMC NORTHWOOD	193.01	0	580, 113		0		17.00
18.00	MGH FMC GAS CITY	193.02	Ö	294, 627		0		18.00
19.00	MGH HOSPI TALI STS	193.03	0	2,995,774		0		19.00
20.00	MGH MAR FAM PRACT	193.03	0	1, 254, 344		0		20.00
20.00	MGH FMC SWAYZEE	193.04	0	84, 615		0		20.00
21.00	MGH PEDIATRIC CTR	193.05	0	431, 794		0		21.00
22.00	MGH SPECIALTY PHYS	193.00	0	163, 337		0		22.00
23.00 24.00	MGH SPECIALITY PHYS MGH FMC CONVERSE	193.07	0	103, 337		0		23.00
24.00 25.00	MGH FMC CONVERSE MGH UPLAND HEALTH	193.08	0	634, 161		0		24.00
			0			0		
26.00	OB/GYN	193.12	-	1, 411, 772		-		26.00
27.00	MGH WOUND CARE	193.18	0	19, 758		0		27.00
28.00	HEART FAILURE CLINIC	194.00	0	33, 037		0		28.00
29.00	MGH WORK SOLUTIONS	194.04	0	246, 613		0		29.00
30.00	MGH TAYLOR UNIVERSITY	1 <u>94.</u> 05		7 <u>0,9</u> 40		익		30.00
	TOTALS		0	22,027,302		_		
500 00	Grand Total: Decreases		2,805,596	37, 145, 001	1	1		500.00

2.00 Land Improvements 3,353,531 0 0 0 0 0 2.00 3.00 Buildings and Fixtures 139,652,631 3,074,848 0 3,074,848 711 3.0 4.00 Building Improvements 3,551,212 204,848 0 204,848 67,530 0	Health Financial Systems	MARION GENERA	AL HOSPITAL		In Li	eu of Form CMS-	2552-10
Beginning Balances Purchases Donation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 Land 5.00 0 0 0 0 0 0 0 2.00 2.00 Land Improvements 3,353,531 0 0 0 0 2.0 2.00 3.00 Buil ding Improvements 3,353,531 0 0 0 0 2.0 2.0 3.00 Buil ding Improvements 3,551,212 204,848 0 3,074,848 711 3.0 5.00 Fixed Equipment 72,737,687 0	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0011	From 07/01/201	9 Part I O Date/Time Pre	pared:
Bal ances Retirements 1.00 2.00 3.00 4.00 5.00 PART 1 - ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 5,191,830 0 0 0 0 2.00 2.00 Land Improvements 3,353,531 0 0 0 2.00 2.00 3.00 Buil Idings and Fixtures 139,652,631 3,074,848 0 3,074,848 711 3.00 4.00 Buil Idings and Fixtures 139,652,631 3,074,848 0 204,848 67,530 4.00 5.00 Fixed Equipment 3,509,530 0				Acqui si ti on	IS		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00 1.00 Land 5,191,830 0 0 0 0 2.00 Land Improvements 3,353,531 0 0 0 0 2.0 3.00 Building provements 3,353,531 0 0 0 0 2.0 4.00 Building provements 3,551,212 204,848 0 2.04,848 67,530 4.0 0		Begi nni ng	Purchases	Donati on	Total	Disposals and	
PART I - ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 191, 830 0 0 0 0 1.00 2.00 Land Improvements 3, 353, 531 0 0 0 0 2.00 3.00 Buil Idi ngs and Fixtures 139, 652, 631 3, 074, 848 0 3, 074, 848 711 3.00 4.00 Buil Idi ng Improvements 3, 551, 212 204, 848 0 204, 848 67, 530 4.00 5.00 Fixed Equipment 72, 737, 687 4, 779, 102 0 4, 779, 102 3, 066, 248 6.0 0		Bal ances				Retirements	
1.00 Land 5,191,830 0		1.00	2.00	3.00	4.00	5.00	
2.00 Land Improvements 3,353,531 0 0 0 0 2.00 3.00 Buildings and Fixtures 139,652,631 3,074,848 0 3,074,848 711 3.0 4.00 Building Improvements 3,551,212 204,848 0 204,848 67,530 0	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
3.00 Buildings and Fixtures 139,652,631 3,074,848 0 3,074,848 711 3.0 4.00 Building Improvements 3,551,212 204,848 0 204,848 67,530 4.0 5.00 Fixed Equipment 3,509,530 0 0 0 0 5.00 6.00 Movable Equipment 72,737,687 4.779,102 0 4.779,102 3,066,248 6.0 7.00 HIT designated Assets 0 0 0 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 227,996,421 8,058,798 0 8,058,798 0 9.00 0<	1.00 Land	5, 191, 830	0		0	0 0	1.00
4.00 Building Improvements 3,551,212 204,848 0 204,848 67,530 4.00 5.00 Fixed Equipment 3,509,530 0 0 0 0 5.00 6.00 Movable Equipment 72,737,687 4,779,102 0 4,779,102 3,066,248 6.0 7.00 HIT designated Assets 0 0 0 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 227,996,421 8,058,798 0 8,058,798 3,134,489 8.0 9.00 Reconciling Items 0 0 0 0 0 0 0 9.0 10.00 Total (line 8 minus line 9) 227,996,421 8,058,798 0 8,058,798 3,134,489 10.0 10.00 Total (line 8 minus line 9) 227,996,421 8,058,798 0 8,058,798 3,134,489 10.0 2.00 Land 5,191,830 0 10.0 10.0 2.0 3,353,531 0 2.0 3.00 Buildings and Fixtures 3,509,530 0 3.00 3.00 3,	2.00 Land Improvements	3, 353, 531	0		0	0 0	2.00
5.00 Fixed Equipment 3,509,530 0 0 0 0 0 5.00 6.00 Movable Equipment 72,737,687 4,779,102 0 4,779,102 3,066,248 6.00 7.00 HIT designated Assets 0	3.00 Buildings and Fixtures	139, 652, 631	3, 074, 848		0 3, 074, 84	8 711	3.00
6.00 Movable Equipment 72,737,687 4,779,102 0 4,779,102 3,066,248 6.0 7.00 HIT designated Assets 0 0 0 0 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 227,996,421 8,058,798 0 8,058,798 3,134,489 8.0 9.00 Reconciling Items 0	4.00 Building Improvements	3, 551, 212	204, 848		0 204, 84	8 67, 530	4.00
7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 227,996,421 8,058,798 0 8,058,798 3,134,489 8.0 9.00 Reconciling Items 0 <	5.00 Fixed Equipment	3, 509, 530	0		0	0 0	5.00
8.00 Subtotal (sum of lines 1-7) 227,996,421 8,058,798 0 8,058,798 3,134,489 8.0 9.00 Reconciling ltems 0 0 0 0 0 0 9.0 10.00 Total (line 8 minus line 9) 227,996,421 8,058,798 0 8,058,798 3,134,489 10.0 Ending Balance Balance 6.00 7.00 7.00 7.00 7.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.00 1.00 7.00 1.00 1.00 1.00 1.00 1.00 2.00 1.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 3.353, 531 0 1.00 2.00 3.00 Building Improvements 3,688,530 0 4.00 3.00 4.00 3.509,530 0 4.00 5.00 5.00 5.00 5.00 6.00 7.00 5.00 5.00 6.00 7.00	6.00 Movable Equipment	72, 737, 687	4, 779, 102		0 4, 779, 10	2 3, 066, 248	6.00
9.00 Reconciling Items 0	7.00 HIT designated Assets	0	0		0	0 0	7.00
9.00 Reconciling Items 0	8.00 Subtotal (sum of lines 1-7)	227, 996, 421	8, 058, 798		0 8, 058, 79	8 3, 134, 489	8.00
Ending Balance Fully Depreciated Assets 6.00 7.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 191, 830 0 2.00 Land Improvements 3, 353, 531 0 3.00 Buildings and Fixtures 142, 726, 768 0 3.00 4.00 Building Improvements 3, 688, 530 0 4.00 5.00 Fixed Equipment 3, 509, 530 0 5.00 6.00 Movable Equipment 74, 450, 541 0 5.00 8.00 Subtotal (sum of lines 1-7) 232, 920, 730 0 8.00	9.00 Reconciling Items	0	0		0	0 0	9.00
Ending Balance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 191, 830 0 2.00 Land Improvements 3, 353, 531 0 3.00 Buildings and Fixtures 142, 726, 768 0 3.00 4.00 Building Improvements 3, 688, 530 0 4.00 5.00 Fixed Equipment 3, 509, 530 0 5.00 6.00 Movable Equipment 74, 450, 541 0 5.00 8.00 Subtotal (sum of lines 1-7) 232, 920, 730 0 8.00	10.00 Total (line 8 minus line 9)	227, 996, 421	8, 058, 798		0 8, 058, 79	8 3, 134, 489	10.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 5,191,830 0 1.00 2.00 Land Improvements 3,353,531 0 2.0 3.00 Buil dings and Fixtures 142,726,768 0 3.0 4.00 Buil ding Improvements 3,688,530 0 4.00 5.00 Fixed Equipment 74,450,541 0 5.00 5.00 7.00 HIT designated Assets 0 0 7.00 7.00 8.00 Subtotal (sum of lines 1-7) 232,920,730 0 8.00		Endi ng	Fully			·	
6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 191, 830 0 2.00 Land Improvements 3, 353, 531 0 3.00 Buildings and Fixtures 142, 726, 768 0 3.0 4.00 Building Improvements 3, 688, 530 0 4.00 5.00 Fixed Equipment 3, 509, 530 0 5.00 6.00 Movable Equipment 74, 450, 541 0 6.00 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232, 920, 730 0		Bal ance	Depreciated				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 191, 830 0 1.0 2.00 Land Improvements 3, 353, 531 0 2.0 3.00 Buildings and Fixtures 142, 726, 768 0 3.0 4.00 Building Improvements 3, 688, 530 0 4.0 5.00 Fixed Equipment 3, 509, 530 0 5.00 6.00 Movable Equipment 74, 450, 541 0 6.0 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232, 920, 730 0 8.0			Assets				
1.00 Land 5, 191, 830 0 1.0 2.00 Land Improvements 3, 353, 531 0 2.0 3.00 Buildings and Fixtures 142, 726, 768 0 3.0 4.00 Building Improvements 3, 688, 530 0 4.0 5.00 Fixed Equipment 3, 509, 530 0 5.0 6.00 Movable Equipment 74, 450, 541 0 6.0 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232, 920, 730 0 8.0			7.00				
2.00 Land Improvements 3, 353, 531 0 2.0 3.00 Buildings and Fixtures 142, 726, 768 0 3.0 4.00 Building Improvements 3, 688, 530 0 4.0 5.00 Fixed Equipment 3, 509, 530 0 5.0 6.00 Movable Equipment 74, 450, 541 0 6.0 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232, 920, 730 0 8.0	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
3.00 Buildings and Fixtures 142,726,768 0 3.00 4.00 Building Improvements 3,688,530 0 4.00 5.00 Fixed Equipment 3,509,530 0 5.0 6.00 Movable Equipment 74,450,541 0 6.0 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232,920,730 0 8.0	1.00 Land	5, 191, 830	0				1.00
4.00 Building Improvements 3,688,530 0 4.0 5.00 Fixed Equipment 3,509,530 0 5.0 6.00 Movable Equipment 74,450,541 0 6.0 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232,920,730 0 8.0	2.00 Land Improvements	3, 353, 531	0				2.00
5.00 Fixed Equipment 3,509,530 0 5.0 6.00 Movable Equipment 74,450,541 0 6.0 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232,920,730 0 8.0	3.00 Buildings and Fixtures	142, 726, 768	0				3.00
6.00 Movable Equipment 74,450,541 0 6.0 7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232,920,730 0 8.0	4.00 Building Improvements	3, 688, 530	0				4.00
7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232,920,730 0 8.0	5.00 Fixed Equipment	3, 509, 530	0				5.00
7.00 HIT designated Assets 0 0 7.0 8.00 Subtotal (sum of lines 1-7) 232,920,730 0 8.0	6.00 Movable Equipment	74, 450, 541	0				6.00
		0	0				7.00
	8.00 Subtotal (sum of lines 1-7)	232, 920, 730	0				8.00
	9.00 Reconciling Items	0	0				9.00
		232, 920, 730	0				10.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:
					11/20/2020 1:	17 pm
		SL	JMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	<u>/N 2, LINES 1 a</u>	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	13, 201, 863	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	13, 201, 863	0		0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	0ther	Total (1)	1			
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	/N 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	13, 201, 863				1.00
3.00 Total (sum of lines 1-2)	0	13, 201, 863				3.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2019 To 06/30/2020		pared:
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		•			
1.00 NEW CAP REL COSTS-BLDG & FIXT	227, 996, 425	0	227, 996, 42	5 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	227, 996, 425		227, 996, 42			3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1		1		i	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	-		0 13, 201, 863		1.00
3.00 Total (sum of lines 1-2)	0	0		13, 201, 863	-1, 062, 234	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					_
1.00 NEW CAP REL COSTS-BLDG & FIXT	-84, 005			0 C	12, 055, 624	1.00
3.00 Total (sum of lines 1-2)	-84, 005	0	1	0 0	12, 055, 624	3.00

I Systems	MARION GENERAL HOSPITAL

Health Financial Systems ADJUSTMENTS TO EXPENSES

				Тс		Date/Time Pre 11/20/2020 1:	
				Expense Classification on To/From Which the Amount is ⁻			
	Cost Center Description	Basi s/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)			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.0
00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	
00	Investment income - other (chapter 2) Trade, quantity, and time		0		0. 00 0. 00	0	
00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	
00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.0
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0. 00	0	7.0
00	21) Television and radio service (chapter 21)		0		0.00	0	8.0
00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -6, 547, 528		0.00	0 0	
I.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.
2.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	12.
3.00 4.00 5.00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee	В	0 -3, 373 0	CAFETERI A	0.00 6.01 0.00	0 0 0	14.
b. 00	and others Sale of medical and surgical supplies to other than		Ο		0.00	0	16.
. 00	patients Sale of drugs to other than patients		0		0.00	0	17.
. 00	Sale of medical records and abstracts		0		0.00	0	18.
. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.
. 00	Vending machines		0		0.00	0	
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	O	PHYSI CAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25.
. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.
. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.
	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	-	28.
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 30.
. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDI ATRI CS	30. 00		30.

Heal th	Fi nan	ici a	I Systems
AD JUST	MENTS	TO	EXPENSES

ADJUST	MENTS TO EXPENSES			F	eriod: rom 07/01/2019 o 06/30/2020	Worksheet A-8 Date/Time Pre 11/20/2020 1:	pared:
				T			
						11/20/2020 1.	
						11/20/2020 1.	1/pm
				Expense Classification on			
				To/From Which the Amount is	to be Aujusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	cost center bescription	(2)	Amourt			Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of						
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
32.00	Depreciation and Interest		0	/	0.00	0	32.00
33.00	FINANCE BANK SERVICE CHARGES	А	-247, 175	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
33.01	FINANCE DISCOUNT PAYMENTS	А		ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02	GAIN ON DISPOSAL	А		ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03	XIX ASSESSMENT FEE A/C	A	-12, 060, 945	ADMI NI STRATI VE & GENERAL	5.00	0	33.03
22 04	7200. 7892	^	2 949 001	ENDLOVEE DENEELTS DEDADTMENT	4 00	0	33.04
33.04 33.05	SELF INSURANCE EXPENSE DEPOSITION-OTHER	A B		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4.00 5.00	0	
33.06	RETURNED CHECK FEE	B		ADMINISTRATIVE & GENERAL	5.00	0	
33.07	PHYSICIAN PRIV APPLIC	В		ADMINISTRATIVE & GENERAL	5.00	0	
33.08	SALE OF MEDICAL RECORDS &	В	-38, 928	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
~~ ~~	ABSTRACTS		0.110		5 00		
33.09	CHILD SEAT SAFETY INSPECTION	В		ADMINISTRATIVE & GENERAL	5.00	0	
33. 10 33. 11	HEALTH SCREENING FEES - LAB HEALTH SCREENING FEES - RAD	B		LABORATORY RADI OLOGY-DI AGNOSTI C	60.00 54.00	0	
33.12	MED STAFF OTHER SCREENING-MED	В		ADMINI STRATI VE & GENERAL	5.00	0	
	STAFF	_				-	
33.13	HEALTH SCREENS	В	-4,653	LABORATORY	60.00	0	33.13
33.14	HEALTH SCREENS	В		LABORATORY	60.00	0	
33.15	REBATE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.16 33.17	REBATE RENTAL OF PROVIDER SPACE BY	B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00	0	
33.17	SUPPLIER	D	-1,200	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33. 18	RENT SPACE UPLAND	В	-18, 819	LABORATORY	60.00	0	33.18
33.19	PAGER RENTAL	В	-950	ADMI NI STRATI VE & GENERAL	5.00	0	33.19
33.20	SALE OF SCRAP, WASTE, ETC,	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.21	PCC MARKETING AG	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 22 33. 23	EDUCATIONAL WORKSHOP OPT HEALTH LINEN SEV	B		ADMINISTRATIVE & GENERAL LAUNDRY & LINEN SERVICE	5.00	0	
33.23	AMBULANCE SVC - ASSISTS	B		AMBULANCE SERVICES	8.00 95.00	0	
33.25	AMBULANCE SVC - CORONER SVC	B		AMBULANCE SERVICES	95.00	0	33.25
33.26	AMBULANCE SVC - LINEN SERVICES	В	-4,608	AMBULANCE SERVICES	95.00	0	
33. 27	AMBULANCE SVC - COMMUNITY	В	-2, 559	AMBULANCE SERVICES	95.00	0	33.27
	EVENT STAF	_					
33. 28	CONTRACT ARU OTH ARU MEDICAL	В	-58, 084	SUBPROVIDER – IRF	41.00	0	33.28
33. 29	DIRECTO MGH UNCLAIMED OTH 125	В	-11 984	ADMINISTRATIVE & GENERAL	5.00	0	33.29
00.27	MED/CHI LD	D	11, 701		0.00	0	00.27
33.30	SCHOOL PHYS OTH SCHOOL PHYS	В	-6, 625	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33. 31	PHLEBOTOMY	В		LABORATORY	60.00	0	•
33.32	CPR TRAIN OTH AHA COMMUNITY	В		ADMINISTRATIVE & GENERAL	5.00	0	
33.33	CLINICAL STUDY- OTHER	В			60.01	0	
33.34 33.35	SICK CHILD CARE PROGRAM ONC. QUAL	B		ADULTS & PEDIATRICS ADMINISTRATIVE & GENERAL	30.00 5.00	0	
33.35	SETTLEMENTS	B		ADMINISTRATIVE & GENERAL	5.00	0	
33.37	UNCLAIMED OTHER MONIES	В		ADMI NI STRATI VE & GENERAL	5.00	0	
	RECOVERED						
33.38	VENDING MACHINES	В			6.01	0	
33.39	MISC REV	B		ADMINISTRATIVE & GENERAL	5.00	0	
33. 40 33. 41	TELEVISION AND RADIO SERVICE TELEPHONE SERVICE	A A		OPERATION OF PLANT OPERATION OF PLANT	7.00 7.00	0	
33.41	OPERATING INTEREST INCOME	В		NEW CAP REL COSTS-BLDG &	1.00	11	
.=				FIXT			
33.43	LOBBYING COSTS	А		ADMINISTRATIVE & GENERAL	5.00	0	
33.44		A		PHARMACY	15.00	0	
33.45	LOBBYING COSTS	A		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.46 33.47	LOBBYING COSTS ELIMINATING ENTRIES	A A		ONCOLOGY MGH PHYS PRACT MGMT	60. 01 192. 14	0	
	ELIMINATING ENTRIES	A		MGH PHYS PRACT MGMT MGH WORK SOLUTIONS	192.14 194.04	0	
	ELIMINATING ENTRIES	A		LUNG CENTER	194.04	0	
	ELIMINATING ENTRIES	A		MGH MARION SURGEONS	192.15	0	
	ELIMINATING ENTRIES	А		MGH FMC SOUTH	192. 17	0	

Health Financial Systems		MARI ON GENERA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Peri od:	Worksheet A-8		
				From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/20/2020 1:	
			Expense Classification or	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
				-		
				1.1		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	2.00	3.00	4.00	Ref. 5.00	
33. 52 ELIMINATING ENTRIES	A		MGH FAIRM MED ASSOC	4.00	5.00	33.52
33. 53 ELIMINATING ENTRIES	A		MGH FAIRM MED ASSOC	192.18	0	
33. 54 ELIMINATING ENTRIES	A		MGH FMC GAS CITY	192.19	0	
33. 55 ELIMINATING ENTRIES	A		MGH FMC SWAYZEE	193.02	0	33.54
33. 56 ELIMINATING ENTRIES	A		MGH PEDIATRIC CTR	193.05	0	
33. 57 ELIMINATING ENTRIES	A	-60, 182		193.00	0	
33. 58 ELIMINATING ENTRIES	A		MGH SPECIALTY PHYS	192.00	0	33.58
33. 59 PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	1
33. 60 ENTERTAI MENT EXP	A		ADMINI STRATI VE & GENERAL	5.00	0	33.60
33. 61 EMPLOYEE USE OF AUTO	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.61
33. 62 DONATIONS	A		ADMINI STRATI VE & GENERAL	5.00	0	1
33. 63 VHA OPPORTUNI TY	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33. 64 VHA OPPORTUNI TY	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 65 VHA OPPORTUNI TY	A		OPERATION OF PLANT	7.00	0	
33. 66 VHA OPPORTUNI TY	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 67 VHA OPPORTUNI TY	A		HOUSEKEEPING	9.00	0	1
33. 68 VHA OPPORTUNI TY	A		DI ETARY	10.00	0	
33. 69 VHA OPPORTUNI TY	A	-821	CENTRAL SERVICES & SUPPLY	14.00	0	33.69
33. 70 VHA OPPORTUNI TY	A	-29, 259	PHARMACY	15.00	0	33.70
33. 71 VHA OPPORTUNI TY	A	-6, 752	ADULTS & PEDIATRICS	30.00	0	33.71
33. 72 VHA OPPORTUNI TY	A	-794	INTENSIVE CARE UNIT	31.00	0	33.72
33. 73 VHA OPPORTUNI TY	A	-165	SUBPROVI DER – I RF	41.00	0	33.73
33. 74 VHA OPPORTUNI TY	A	-39, 810	OPERATING ROOM	50.00	0	33.74
33. 75 VHA OPPORTUNI TY	A		RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 76 VHA OPPORTUNI TY	A		CARDI AC CATHETERI ZATI ON	59.00	0	33.76
33. 77 VHA OPPORTUNI TY	A		LABORATORY	60.00	0	
33. 78 VHA OPPORTUNI TY	A		ONCOLOGY	60. 01	0	00.70
33. 79 VHA OPPORTUNI TY	A		RESPI RATORY THERAPY	65.00	0	
33.80 VHA OPPORTUNI TY	A		PHYSI CAL THERAPY	66.00	0	
33.81 VHA OPPORTUNI TY	A		ELECTROCARDI OLOGY	69.00	0	
33. 82 VHA OPPORTUNI TY	A		CARDI AC REHAB	69.01	0	
33.83 VHA OPPORTUNI TY	A	-1, 108		90.00	0	
33. 84 VHA OPPORTUNI TY	A		EMERGENCY	91.00	0	00.01
33.85 VHA OPPORTUNI TY	A		AMBULANCE SERVICES	95.00	0	
33.86 ED ON CALL SVC A/C 7000.2512	A		ADMINISTRATIVE & GENERAL	5.00	0	33.86
33. 87 MI SC REV	В		LABORATORY	60.00	0	33.87
50.00 TOTAL (sum of lines 1 thru 49)	/	-28, 240, 376				50.00
(Transfer to Worksheet A,						
column 6, line 200.)	1			1		L

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems		MARI ON GENERAL HOSPI TAL			In Lieu of Form CMS-2552-10			
PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider CCN: 15-0011		Period:	Worksheet A-8	3-2	
						From 07/01/2019 To 06/30/2020	Date/Time Pre	narad
						10 06/30/2020	11/20/2020 1:	17 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
-	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		SUBPROVIDER – IRF	6, 550		C	0	0	1.00
2.00		ELECTROCARDI OLOGY	53, 802		C		0	2.00
3.00		OPERATING ROOM	1, 164, 318		C		0	3.00
4.00		CLINIC	0	0	C	0	0	4.00
5.00		EMERGENCY	5, 174, 034		C	0	0	5.00
6.00		LABORATORY	11, 100		C	0	0	6.00
7.00		RADI OLOGY-DI AGNOSTI C	137, 724		C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00				C	0	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	6, 547, 528 Unadj usted RCE		Cost of		0 Physician Cost	200.00
	WKSL A LINE #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		rdentifier		Limit	Continuing	Share of col.	Insurance	
					Education	12	Thou ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		SUBPROVIDER - IRF	0.00	0			0	1.00
2.00		ELECTROCARDI OLOGY	0	0			0	2.00
3.00		OPERATING ROOM	0	0	C	0	0	3.00
4.00	90.00	CLINIC	0	0	C	0	0	4.00
5.00	91.00	EMERGENCY	0	0	C	0	0	5.00
6.00	60.00	LABORATORY	0	0	C	0	0	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	7.00
8.00	0. 00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0	C	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	14.00	17.00	10.00		
1 00	1.00	2.00	15.00	16.00	17.00	18.00		1 00
1.00			0	, v	C			1.00
2.00 3.00		ELECTROCARDI OLOGY OPERATI NG ROOM		0	C			2.00 3.00
3.00 4.00		CLINIC	0	0		1, 164, 318 0		3.00 4.00
4.00 5.00		EMERGENCY		0		5, 174, 034		4.00 5.00
5.00 6.00		LABORATORY	0	0		11, 100		5.00 6.00
7.00		RADI OLOGY-DI AGNOSTI C		0	0			7.00
8.00	0.00			0		137,724		8.00
9.00	0.00			0		0		9.00
9.00 10.00	0.00			0		0		10.00
200.00	0.00			0	9	6, 547, 528		200.00
	I	1		. 0		1 2, 3 , 320		

	Financial Systems	MARION GENER				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 07/01/2019	Worksheet B Part I	
					06/30/2020	Date/Time Pre	epared:
			CAPI TAL			11/20/2020 1:	17 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
		for Cost	FLXT	BENEFITS		E & GENERAL	
		Allocation (from Wkst A		DEPARTMENT			
		col. 7)					
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS				1		
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT	12,055,624					1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	16, 531, 552 23, 454, 056				30, 600, 686	
6.00	00600 MAI NTENANCE & REPAI RS	20, 101, 000	0,701,170	0, 112, 101		0	1
6.01	00601 CAFETERI A	1, 418, 505	134, 488	0	1, 552, 993	358, 940	6.01
6.02	00602 CAFETERI A	0	0	0	0	0	6.02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	5, 468, 804 289, 818		178, 910	8, 203, 317 348, 326	1, 896, 016 80, 508	
8.00 9.00	00900 HOUSEKEEPING	2, 621, 756				626, 825	1
10.00	01000 DI ETARY	516, 225			1 1 1 1	163, 173	1
13.00	01300 NURSI NG ADMI NI STRATI ON	910, 027	19, 272	194, 778	1, 124, 077	259, 806	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	472, 768				133, 204	
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	3, 549, 903	85, 007	610, 361	4, 245, 271	981, 201	15.00
30.00	03000 ADULTS & PEDIATRICS	6, 917, 306	1, 189, 874	1, 348, 735	9, 455, 915	2, 185, 527	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 265, 821		407, 949		683, 556	1
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	1, 768, 871	265, 404	239, 650	2, 273, 925	525, 568	
42.00	04200 SUBPROVI DER	1 224 505	0	0	0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 234, 585	0	240, 121	1, 474, 706	340, 846	43.00
50.00	05000 OPERATING ROOM	10, 224, 270	953, 987	270, 713	11, 448, 970	2, 646, 167	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 726, 278		558, 131		1, 353, 762	
57.00	05700 CT SCAN	910, 635		107, 971		245,060	1
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	480, 243 2, 024, 820				135, 190 534, 321	
60.00	06000 LABORATORY	8, 042, 470		516, 587		2, 062, 050	1
60.01	06001 ONCOLOGY	1, 649, 415					
60.02	06002 RADIATION ONCOLOGY	0	0	0	•	0	
65.00		2, 167, 978		327, 690		605, 330	65.00 66.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2, 161, 810 992, 783		429, 234 191, 738		604, 501 324, 680	1
69.01	06901 CARDI AC REHAB	213, 026			1	67, 531	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	-	0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	10, 259, 314	0	0	10, 259, 314	2, 371, 215	73.00
90.00	09000 CLINIC	1, 036, 301	135, 540	68, 047	1, 239, 888	286, 573	90.00
91.00	09100 EMERGENCY	5, 727, 485		1, 886, 613		1, 830, 684	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1, 173, 273	114, 911	247, 420	1, 535, 604	354, 921	95.00
95.00	SPECIAL PURPOSE COST CENTERS	1, 173, 273	114, 911	247, 420	1, 555, 604	504, 921	95.00
113.00	11300 I NTEREST EXPENSE						113.00
118.00		131, 265, 722	12, 018, 825	11, 790, 949	126, 188, 332	22, 092, 974	118.00
400.00	NONREI MBURSABLE COST CENTERS	44 504	0 (700		04.000	10 (4)	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	41, 594	36, 799	6, 606	84, 999		190.00 192.00
	19201 PACT REV PHYSICIANS	631, 898	0	105, 039	736, 937	170, 327	
	19202 VI SI TOR MEALS	0	0	0	0		192.02
	19203 GREAT BEGI NNI NGS/MATERNAL	104, 091	0	23, 182	127, 273		192.03
	19204 LI FELI NE	0	0	0	0		192.04
	19205 OWNED PROPERTIES 19206 UROLOGY	335, 157		109 529	335, 157	77, 464 332, 779	192.05
	19207 PHYSI CLANS' PRI VATE OFFI CES	1, 241, 275	0	198, 528 0	1, 439, 803		192.00
	19211 PARI SH NURSI NG	74, 856	0	13, 366	88, 222		192.08
192.09	19212 BI OTERRORI SM GRANT	0	0	0	0	0	192.09
	19214 BREAST PUMPS	0	0	0	0		192.10
	19208 MGH EMERGENCY PHYSI CLANS	704 004	0	144 100	022 104		192.11
	19209 LUNG CENTER 19213 MGH EXPRESS	786, 996 1, 314, 486		146, 198 219, 369		215, 687 354, 517	
	19210 MGH PHYS PRACT MGMT	1, 840, 206		264, 621		486, 484	
192.15	19215 MGH MARION SURGEONS	1, 961, 243	0	369, 557	2, 330, 800	538, 713	192.15
	19216 MGH MGH MED ONC	1, 417, 992		268, 565		389, 811	
	19217 MGH FMC SOUTH	2,651,186		425, 349		711,073	
192.18	19218 MGH FAIRM MED ASSOC	516, 558	0	73, 048	589, 606	136, 274	ןו∍∠. וס

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0011	Peri od:	Worksheet B	
				From 07/01/2019	Part I	
				To 06/30/2020		
		CAPI TAL			11/20/2020 1:	
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
cost center bescription	for Cost	FIXT	BENEFITS	Subtotal	E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A		DELARTMENT			
	col. 7)					
	0	1.00	4.00	4A	5.00	
192.19 19219 MGH FMC MARION	828, 337	0	148, 28		225, 725	192 19
193. 00 19300 NONPAI D WORKERS	0	0	1.0720	0 0		193.00
193. 01 19301 MGH FMC NORTHWOOD	1, 170, 107	-	209, 33	1, 379, 441	318, 827	
193. 02 19302 MGH FMC GAS CITY	767, 437		119, 61		205, 022	
193. 03 19303 MGH HOSPI TALI STS	3, 688, 550		695, 77		1,013,339	•
193. 04 19304 MGH MAR FAM PRACT	3, 119, 377		529, 27		843, 306	•
193. 05 19305 MGH FMC SWAYZEE	257, 614		41, 09		69,041	
193. 06 19306 MGH PEDI ATRI C CTR	1, 035, 583	-	155, 08		275, 197	•
193.07 19307 MGH SPECIALTY PHYS	288, 125		51, 29		78, 450	
193. 08 19308 MGH FMC CONVERSE	348, 549		49, 63		92, 032	
193. 09 19309 MGH UPLAND HEALTH	1, 723, 291	0	259, 86		458, 364	
193. 10 19310 MGH MGH WOMENS CTR	0	-	207,00	0 0		193.10
193. 11 19311 MGH MGH PSYCHIATRY	0			0 0		193.11
193. 12 19312 OB/GYN	2, 893, 110	-	459, 19		774, 812	
193. 15 19315 MGH RIVER VIEW BLDG	2,0,0,110	0	107,17	0 0,002,000		193.15
193. 16 19316 MGH NEONATOLOGY	889, 400	0		0 889, 400	205, 565	
193. 18 19318 MGH WOUND CARE	24, 160		4, 59			193.18
194. 00 07963 HEART FAILURE CLINIC	51, 647	-	7,67		13, 712	
194. 01 07950 MOW	01,017		,,,,,,	0 0		194.01
194. 02 07951 MENTAL HEALTH	0	0		0 0		194.02
194. 03 07952 ADVERTI SI NG	218, 861	0	26,00	-	56, 594	
194. 04 07953 MGH WORK SOLUTIONS	888, 662	0	121, 19		233, 406	
194. 05 07954 MGH TAYLOR UNI VERSI TY	110, 752		21, 11		30, 477	
194. 06 07955 OPI OI D I MPL GRANT	212, 589		10, 09		51, 469	
194. 07 07956 ASTHMA GRANT	5, 086		72			194.07
194.08 07957 MGH_SMMP_BLDG	0			0 0		194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0		194.09
194.1007959 MGH 106 LYONS BLDG	7, 573	0		0 7,573		194.10
194. 11 07960 FAI RMOUNT	0			0 0		194.11
194. 12 07961 GAS CI TY	0	0		0 0		194.12
194. 13 07969 LYONS	0	0		0 0	0	194.13
194. 14 07964 WABASH	0	0		0 0	0	194.14
194. 15 07965 TOBACCO GRANT	53, 401	0	8, 52	61, 921	14, 312	194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	11, 110	0	45			194.16
194. 17 07967 HRSA OPI OI D PLANNI NG	113, 695		3, 17		27,011	
194. 18 07962 ECHO GRANT	80			0 80		194.18
194. 19 07968 RURAL QI GRANT	107, 508		5, 16		26, 041	
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	162, 997, 864	12, 055, 624	16, 831, 54	0 162, 997, 864	30, 600, 686	202.00

COST A	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	MARI ON GENERA	Provider CC		Period: From 07/01/2019	u of Form CMS-: Worksheet B Part I	
					To 06/30/2020		epared:
	Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
		REPAIRS 6.00	6. 01	6.02	PLANT 7.00	LINEN SERVICE 8.00	
	GENERAL SERVICE COST CENTERS	0.00	0.01	0.02	7.00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	0					5.00
6.01	00601 CAFETERI A	0	1, 911, 933				6.0
6. 02	00602 CAFETERI A	0	1, 857, 516	1, 857, 51			6.02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	0	54, 69	6 10, 154, 029 0 110, 816	E20 (E0	7.00
8.00 9.00	00900 HOUSEKEEPING	0	0			539, 650 0	1
10.00	01000 DI ETARY	0	0	44		215	
13.00	01300 NURSING ADMINISTRATION	0	0	28, 76		0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	12, 27 97, 33		202 0	
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	U	77, 33	101,000	0	15.0
30. 00	03000 ADULTS & PEDIATRICS	0	0	274, 43	3 2, 253, 666	113, 607	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	79, 81		23, 066	
40.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0	47, 47	0 0 6 502,685	0 12, 050	
42.00	04200 SUBPROVI DER	0	0	ч <i>7</i> , ч7 (0 0	0	42.0
43.00	04300 NURSERY	0	0	46, 56	2 0	0	43.0
	ANCI LLARY SERVI CE COST CENTERS		0	1/1 50	1 00/ 007	00.026	
50.00 51.00	05100 RECOVERY ROOM	0	0	161, 58	7 1, 806, 887 0 0	80, 936 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	Ő	129, 51	-	36, 919	
57.00	05700 CT SCAN	0	0	24, 22		18, 709	
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0	12, 39		0	
59.00 50.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0	0	30, 76 124, 05		5, 345 0	59.0 60.0
50.01	06001 ONCOLOGY	0	0			2, 927	
50. 02	06002 RADIATION ONCOLOGY	0	0		0 0	0	60.0
65.00	06500 RESPIRATORY THERAPY	0	0	57,83		3, 967	
56.00 59.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	0	33, 20 48, 19		13, 092 3, 960	
69.01	06901 CARDI AC REHAB	0	0	8, 24		0,700	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0			0	
/3.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	V		<u> </u>	0	13.0
90.00	09000 CLI NI C	0	0	15, 32		2, 181	90.0
91.00	09100 EMERGENCY	0	0	222, 21	4 580, 618	202, 868	
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(0 0	0	92.0 92.0
/2.01	OTHER REIMBURSABLE COST CENTERS		0				/2.0
95.00	09500 AMBULANCE SERVICES	0	0	68, 12	217, 647	16, 951	95.0
113 00	SPECIAL PURPOSE COST CENTERS						113.0
118.00		0	1, 857, 516	1, 577, 49	7 10, 084, 330	536, 995	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1, 33	69, 699		190.0
	19200 PHYSICIANS' PRIVATE OFFICES 19201 PACT REV PHYSICIANS	0	0	17, 78			192.0 192.0
	19202 VI SI TOR MEALS	0	54, 417	(192.0
	19203 GREAT BEGI NNI NGS/MATERNAL	0	0	(0 0		192.0
		0	0	(0		192.0
	19205 OWNED PROPERTIES 19206 UROLOGY	0	0	33, 29			192.0 192.0
	19207 PHYSI CLANS' PRI VATE OFFI CES	0	0	(o o		192.0
	19211 PARI SH NURSI NG	0	0	3, 60	5 0		192.0
	19212 BI OTERRORI SM GRANT	0	0	(0		192.0 192.1
	19214 BREAST PUMPS 19208 MGH EMERGENCY PHYSICIANS	0	0				192.1
	19209 LUNG CENTER	0	o	17, 09	7 0		192.1
	19213 MGH EXPRESS	0	0	(192.1
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	0	0	81, 938 45, 15			192.1 192.1
	19216 MGH MARION SURGEONS	0	0				192.1
92.1	19217 MGH FMC SOUTH	0	o			16	192.1
	19218 MGH FAI RM MED ASSOC	0	0	(0 0		192.1
	9 19219 MGH FMC MARION 9 19300 NONPAID WORKERS	0	0	30, 09			192.1 193.0
	19300 NONPALD WORKERS	0	0				193.0
	19302 MGH FMC GAS CITY	0	Ő	(o o	27	193.0
	19303 MGH HOSPI TALI STS	0	0		0 0		193.0

Health Financial Systems	MARI ON GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0011	Peri od:	Worksheet B	
				From 07/01/2019	Part I	norod.
				To 06/30/2020	Date/Time Pre 11/20/2020 1:	17 pm
Cost Center Description	MAINTENANCE &	CAFETERIA	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6. 01	6.02	7.00	8.00	
193.04 19304 MGH MAR FAM PRACT	0	0		0 0	445	193.04
193.05 19305 MGH FMC SWAYZEE	0	0		0 0	25	193.05
193. 06 19306 MGH PEDIATRIC CTR	0	0	25, 7	10 0	56	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	8, 90	02 0	28	193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 0	105	193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 0		193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0		193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0 0		193.11
193. 12 19312 OB/GYN	0	0		0 0		193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0		193.15
193.16 19316 MGH NEONATOLOGY	0	0		0 0		193.16
193.18 19318 MGH WOUND CARE	0	0		0 0		193. 18
194.0007963 HEART FAILURE CLINIC	0	0		0 0		194.00
194. 01 07950 MOW	0	0		0 0		194.01
194. 02 07951 MENTAL HEALTH	0	0		0 0		194.02
194. 03 07952 ADVERTI SI NG	0	0	6, 1			194.03
194. 04 07953 MGH WORK SOLUTIONS	0	0		0 0		194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0		194.05
194. 06 07955 OPI OLD I MPL GRANT	0	0	3, 9:			194.06
194.07 07956 ASTHMA GRANT	0	0	1!			194.07
194.08 07957 MGH SMMP BLDG	0	0		0 0		194.08
194. 09 07958 MGH AMBUCARE BLDG	0	0		0 0		194.09
194. 10 07959 MGH 106 LYONS BLDG	0	0		0 0		194.10
194. 11 07960 FAI RMOUNT 194. 12 07961 GAS_CI TY	0	0		0 0		194.11
194. 13 07969 LYONS	0	0		0 0		194. 12 194. 13
	0	0		0 0		
194. 14 07964 WABASH	0	0	2, 1			194.14
194.15 07965 TOBACCO GRANT 194.16 07966 HRSA NETWORK DEV PLANNING	0	0	2, 1			194. 15 194. 16
194. 17 07967 HRSA OPIOLD PLANNING	0	0	70			194.10
194. 18 07962 ECHO_GRANT	0	0	/0	0 0		194.17
194. 19 07968 RURAL_QIGRANT	0	0	1, 7			194.18
200.00 Cross Foot Adjustments	0	0	1, 73			200.00
201.00 Negative Cost Centers	0	0		0 0		200.00
202.00 TOTAL (sum lines 118 through 201)	0	1, 911, 933	1, 857, 5	10, 154, 029		
	, V	1, 711, 755	1,007,0	10, 104, 029	557,050	1202.00

Heal th Finar	ncial Systems	MARION GENERA	L HOSPI TAL		In Lieu	」of Form CMS-2	2552-10
	TION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0011 Pe	eriod: com 07/01/2019	Worksheet B Part I	
				Tc		Date/Time Pre	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	11/20/2020 1: PHARMACY	17 pm
	·			ADMI NI STRATI O	SERVICES &		
		9.00	10.00	N 13.00	SUPPLY 14.00	15.00	
	RAL SERVICE COST CENTERS						1 00
	NEW CAP REL COSTS-BLDG & FIXT						1.00 4.00
	ADMI NI STRATI VE & GENERAL						5.00
	MAINTENANCE & REPAIRS						6.00 6.01
6. 02 00602	2 CAFETERI A						6.02
	OPERATION OF PLANT						7.00
) LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG	3, 509, 820					8.00 9.00
10.00 01000	DI ETARY	50, 297	1, 271, 080				10.00
	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	15, 718 78, 590	0	1, 464, 864 0	925, 566		13.00 14.00
	PHARMACY	44, 010	0	0	⁹²³ , 300	5, 528, 827	15.00
	I ENT ROUTI NE SERVI CE COST CENTERS		047 007	054 (00			
	ADULTS & PEDIATRICS	930, 503 176, 041	817, 997 130, 746	351, 623 102, 263	99, 816 36, 297	0	30.00 31.00
	SUBPROVI DER - I PF	0	130, 740	02,203	0	0	40.00
	SUBPROVIDER - IRF	150, 892	133, 662	60, 830	9, 074	0	41.00
) SUBPROVI DER) NURSERY	0	0	0 59, 659	0	0	42.00 43.00
ANCI L	LARY SERVICE COST CENTERS		_				
	OPERATING ROOM RECOVERY ROOM	465, 252 0	0	180, 755 0	117, 964 0	0	50.00 51.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	198, 046	0	0	18, 148	0	54.00
) CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	11,003	0	0	0	0	57.00 58.00
	CARDIAC CATHETERIZATION	62, 872	0	39, 417	36, 297	0	59.00
	LABORATORY	176, 041	0	0	54, 445	0	60.00
	ONCOLOGY RADIATION ONCOLOGY	0	0	0	0	0	60. 01 60. 02
	RESPIRATORY THERAPY	132, 031	0	74, 104	18, 148	0	65.00
		0	0	42, 546	0	0	66.00
	ELECTROCARDI OLOGY	84, 877 94, 308	0	61, 757 10, 567	27, 223 0	0	69.00 69.01
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	I MPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0 5, 528, 827	72.00 73.00
OUTPA	TIENT SERVICE COST CENTERS						
	D CLINIC EMERGENCY	62, 872 704, 165	0 19, 881	19, 632 284, 718	0 45, 371	0	90.00 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	, 61, 100	17,001	201, 710	10, 0, 1		92.00
	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
	AMBULANCE SERVICES	22, 005	0	87, 293	9, 074	0	95.00
	AL PURPOSE COST CENTERS	[]		[[113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 459, 523	1, 102, 286	1, 375, 164	471, 857	5, 528, 827	
	I MBURSABLE COST CENTERS	(207	0				100.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	6, 287 0	0 0	0	0		190. 00 192. 00
	PACT REV PHYSICIANS	0	0	22, 792	0		192.01
	2 VISITOR MEALS GREAT BEGINNINGS/MATERNAL	0	0	0 6, 966	0		192. 02 192. 03
192.04 19204		0	0	0, 700	0		192.03
		0	0	0	0 36, 297		192. 05 192. 06
192.06 19206 192.07 19207	PHYSICIANS' PRIVATE OFFICES	12, 574	0	0	36, 297		192.06 192.07
	PARI SH NURSI NG	6, 287	0	0	0		192.08
	2 BIOTERRORISM GRANT 1 BREAST PUMPS	0	0	0	0		192. 09 192. 10
192. 11 19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192. 11
	PLUNG CENTER 3 MGH EXPRESS	0	0	0 59, 942	0 18, 148		192. 12 192. 13
	MGH PHYS PRACT MGMT	25, 149	0	0	0		192.13
	MGH MARI ON SURGEONS	0	0	0	54, 445		192.15
192. 17 19217	MGH MGH MED ONC MGH FMC SOUTH	ol	0	0	0 45, 371		192. 16 192. 17
192. 18 19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192. 18
	MGH FMC MARION NONPAID WORKERS	0	0	0	27, 223		192. 19 193. 00
193.01 19301	MGH FMC NORTHWOOD	0	0	0	9, 074	0	193.01
193.02 19302	2 MGH FMC GAS CITY	0	0	0	9, 074	0	193.02

Health Financial Systems	MARI ON GENERAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0011	Peri od: From 07/01/2019 To 06/30/2020	Worksheet B Part I Date/Time Pr 11/20/2020 1	epared: :17 pm
Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG ADMI NI STRATI N	SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193. 03 19303 MGH HOSPI TALI STS	0	0		0 0		0 193. 03
193.04 19304 MGH MAR FAM PRACT	0	0		0 54, 445		0 193. 04
193.05 19305 MGH FMC SWAYZEE	0	0		0 9, 074		0 193. 05
193.06 19306 MGH PEDIATRIC CTR	0	0		0 9, 074		0 193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	0		0 0		0 193. 07
193.08 19308 MGH FMC CONVERSE	0	0		0 9, 074	(0 193. 08
193.09 19309 MGH UPLAND HEALTH	0	0		0 18, 148	(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. 1 ⁻
193. 12 19312 OB/GYN	0	0		0 136, 114	() 193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	(0 193. 15
193. 16 19316 MGH NEONATOLOGY	0	0		0 0	(193.16
193.18 19318 MGH WOUND CARE	0	0		0 0	(193. 18
194.0007963 HEART FAILURE CLINIC	o	0		0 0	(194.00
194. 01 07950 MOW	0	44, 583		0 0	(0 194. 0 ⁻
194. 02 07951 MENTAL HEALTH	0	124, 211		0 0		0 194. 02
194. 03 07952 ADVERTI SI NG	0	0		0 0		194.03
194. 04 07953 MGH WORK SOLUTIONS	0	0		0 18, 148		194.04
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0		0 0		0 194. 05
194. 06 07955 OPI 0I D I MPL GRANT	0	0		0 0		194.06
194. 07 07956 ASTHMA GRANT	0	0				0 194.07
194. 08 07957 MGH SMMP BLDG	0	0				194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0		194.00
194. 10 07959 MGH 106 LYONS BLDG	0	0		0 0		0 194. 10
194. 11/07960 FAI RMOUNT	0	0		0 0		0 194. 1
194. 12 07960 PATRMOUNT 194. 12 07961 GAS CI TY	0	0		0 0) 194. 12
	0	0		0 0		
194. 13 07969 LYONS	0	0		0 0		0 194. 13
194. 14 07964 WABASH	0	0		0 0		0 194. 14
194. 15 07965 TOBACCO GRANT	0	0		0 0		0 194. 15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0		0 0		0 194. 16
194. 17 07967 HRSA OPIOID PLANNING	0	0		0 0		0 194. 17
194. 18 07962 ECHO GRANT	0	0		0 0		0 194. 18
194. 1907968 RURAL QI GRANT	0	0		0 0	(0 194. 19
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)	3, 509, 820	1, 271, 080	1, 464, 86	64 925, 566	5, 528, 82	71202 00

Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lieu of Form CMS	8-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0011 P F	Period: Worksheet B From 07/01/2019 Part I	
				o 06/30/2020 Date/Time P 11/20/2020	repared:
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26.00	-	
GENERAL SERVICE COST CENTERS	24.00	23.00	20.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL					4.00 5.00
6. 00 00600 MAI NTENANCE & REPAI RS					6.00
6. 01 00601 CAFETERI A					6.01
6. 02 00602 CAFETERIA 7. 00 00700 OPERATI ON OF PLANT					6.02 7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY 13. 00 01300 NURSI NG ADMI NI STRATI ON					10.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 O1500 PHARMACY					15.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	16, 483, 087	0	16, 483, 087		30.00
31.00 03100 I NTENSI VE CARE UNI T	4, 726, 611	0	4, 726, 611		31.00
40. 00 04000 SUBPROVI DER – I PF 41. 00 04100 SUBPROVI DER – I RF	0	0	0		40.00 41.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	3, 716, 162 0	0	3, 716, 162 0		41.00
43.00 04300 NURSERY	1, 921, 773	0	1, 921, 773		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	16, 908, 518	0	16, 908, 518		50.00
51.00 05100 RECOVERY ROOM	10, 900, 510	0	10, 700, 510		51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 678, 458	0	8, 678, 458		54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 438, 201 826, 063	0	1, 438, 201 826, 063		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 285, 137	0	3, 285, 137		59.00
60. 00 06000 LABORATORY	12, 025, 092	0	12, 025, 092		60.00
60. 01 06001 0NC0L0GY 60. 02 06002 RADI ATI ON ONC0L0GY	2, 324, 362	0	2, 324, 362 0		60. 01 60. 02
65. 00 06500 RESPI RATORY THERAPY	3, 744, 083	0	3, 744, 083		65.00
66. 00 06600 PHYSI CAL THERAPY	3, 354, 987	0	3, 354, 987		66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	2, 372, 606 540, 856	o	2, 372, 606 540, 856		69.00 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS	10 150 254	0	19 150 254		72.00 73.00
OUTPATIENT SERVICE COST CENTERS	18, 159, 356	0	18, 159, 356		/3.00
90. 00 09000 CLI NI C	1, 883, 186	0	1, 883, 186		90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 811, 168	0	11, 811, 168		91.00 92.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS		-			
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	2, 311, 624	0	2, 311, 624		95.00
113. 00 11300 I NTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	116, 511, 330	0	116, 511, 330		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	181, 968	0	181, 968		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		192.00
192. 01 19201 PACT REV PHYSI CLANS 192. 02 19202 VI SI TOR MEALS	947, 844	0	947, 844		192. 01 192. 02
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	54, 417 163, 655	0	54, 417 163, 655		192.02
192. 04 19204 LI FELI NE	0	0	0		192.04
192. 05 19205 OWNED PROPERTIES 192. 06 19206 UROLOGY	412, 621 1, 842, 171	0	412, 621 1, 842, 171		192. 05 192. 06
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES	12, 574	0	12, 574		192.00
192. 08 19211 PARI SH NURSI NG	118, 505	0	118, 505		192.08
192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS	0	0	0		192. 09 192. 10
192. 11 19208 MGH EMERGENCY PHYSICIANS	0	0	0	1	192.11
192. 12 19209 LUNG CENTER	1, 165, 978	0	1, 165, 978		192.12
192.13 19213 MGH EXPRESS 192.14 19210 MGH PHYS PRACT MGMT	1, 966, 462 2, 699, 299	0	1, 966, 462 2, 699, 299		192. 13 192. 14
192.15 19215 MGH MARION SURGEONS	2, 969, 109	0	2, 969, 109	,	192. 15
192.16 19216 MGH MGH MED ONC	2,076,368	0	2,076,368		192.16
192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC	3, 832, 995 725, 905	0	3, 832, 995 725, 905		192. 17 192. 18
192.1919219 MGH FMC MARION	1, 259, 665	Ö	1, 259, 665		192. 19
193.00 19300 NONPALD WORKERS	0	0	0		193.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0011	Period: Worksheet B
				From 07/01/2019 Part I
				To 06/30/2020 Date/Time Prepared: 11/20/2020 1:17 pm
Cost Center Description	Subtotal	Intern &	Total	
cost center bescription	Jubrotai	Residents	Total	
		Cost & Post		
		Stepdown		
		Adjustments		
	24.00	25.00	26.00	
193.01 19301 MGH FMC NORTHWOOD	1, 707, 342	0	1,707,3	342 193.01
193.02 19302 MGH FMC GAS CITY	1, 101, 174	0	1, 101, 1	74 193.02
193. 03 19303 MGH HOSPI TALI STS	5, 397, 660	o	5, 397, 6	
193.04 19304 MGH MAR FAM PRACT	4, 546, 849	0	4, 546, 8	
193.05 19305 MGH FMC SWAYZEE	376, 853		376, 8	
193. 06 19306 MGH PEDIATRIC CTR	1, 500, 735	0	1, 500, 7	
193. 07 19307 MGH SPECIALTY PHYS	426, 802	0	426, 8	
193. 08 19308 MGH FMC CONVERSE	499, 397	0	499, 3	
193. 09 19309 MGH UPLAND HEALTH	2, 460, 618	0	2, 460, 6	
193. 10 19310 MGH MGH WOMENS CTR	2, 100, 010	0	2, 100, 0	0 193.10
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0 193.11
193. 12 19312 OB/GYN	4, 263, 232	0	4, 263, 2	
193. 15 19315 MGH RIVER VIEW BLDG	4, 200, 202	0	4,200,2	0 193.15
193. 16 19316 MGH NEONATOLOGY	1, 094, 965	0	1, 094, 9	
193. 18 19318 MGH WOUND CARE	35, 397	0	35, 3	
194. 00 07963 HEART FAILURE CLINIC	73,037	0	73, C	
194. 01 07950 MOW	44, 583	0	44,5	
194.02 07951 MENTAL_HEALTH	124, 211	0	124, 2	
194. 03 07952 ADVERTI SI NG	307, 628	0	307,6	
194. 04 07953 MGH WORK SOLUTIONS	1, 261, 492	0	1, 261, 4	
194. 05 07954 MGH TAYLOR UNI VERSI TY	162, 339		1, 201, 4	
194. 06 07955 0PI 0I D I MPL GRANT	278, 082	0	278, 0	
194. 07 07956 ASTHMA GRANT	7, 306	0	2,0,0	
194. 08 07957 MGH SMMP BLDG	7,300	0	7,3	0 194.07
194.0907958 MGH AMBUCARE BLDG	0	0		0 194.00
194. 10 07959 MGH 106 LYONS BLDG	9, 323	0	9, 3	
194. 11 07960 FAI RMOUNT	9, 323	0	7, 3	0 194.10
194. 12 07961 GAS_CLTY	0	0		0 194.11
194. 13 07969 LYONS	0	0		0 194.12
194. 14 07964 WABASH	0	0		0 194.13
194. 15 07965 TOBACCO GRANT	78, 412	0	78, 4	
194. 16 07966 HRSA_NETWORK_DEV_PLANNI NG 194. 17 07967 HRSA_OPLOI D_PLANNI NG	14, 353	0	14, 3 144, 6	
194. 17/07967 HRSA OPTOTD PLANNING 194. 18/07962 ECHO GRANT	144, 648 98	0		98 194. 17 194. 17
194. 18 07962 ECHU GRANT 194. 19 07968 RURAL_QI_GRANT	98 140, 462	0	140, 4	
200.00 Cross Foot Adjustments	140, 462	0	140, 4	0 200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0		0 201.00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	0 162, 997, 864		162, 997, 8	
202.00 TOTAL (Sum TIMES TTO UNDUGH 201)	102, 997, 604	l d	102, 777, 8	ןדטק [202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	MARI ON GENER	AL HOSPITAL Provider C		eriod:	u of Form CMS-: Worksheet B	2552-10
					rom 07/01/2019 0 06/30/2020	Date/Time Pre	pared:
	Cost Center Description	Directly Assigned New Capital	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	11/20/2020 1: ADMI NI STRATI V E & GENERAL	<u>17 pm</u>
		Related Costs 0	1.00	2A	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS						1.00
1.00 4.00 5.00 6.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	000000000000000000000000000000000000000	299, 988 3, 704, 496 0		299, 988 61, 376 0	3, 765, 872 0	1.00 4.00 5.00 6.00
6.01	00601 CAFETERI A	0	134, 488	134, 488	0	44, 173	
6. 02 7. 00	00602 CAFETERIA 00700 OPERATION OF PLANT	0	2, 555, 603	0 2, 555, 603	0 3, 188	0 233, 335	6.02 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	58, 508	58, 508	0	9, 908	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	90, 268 185, 298		0 79	77, 141 20, 081	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	105, 296		3, 471	31, 973	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	65, 984	65, 984	669		1
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	0	85,007	85, 007	10, 877	120, 752	15.00
30.00	03000 ADULTS & PEDIATRICS	0	1, 189, 874	1, 189, 874	24, 036	268, 964	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	283, 707		7, 270		31.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER		265, 404		4, 271 0	64, 680 0	41.00
	04300 NURSERY	0	0	0	4, 279	41, 947	1
F0 00	ANCI LLARY SERVICE COST CENTERS		052.007	052.007	4.024	205 (00	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	953, 987 0	953, 987 0	4, 824 0	325, 622 0	50.00 51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	572, 785	572, 785	9, 947	166, 602	
57.00	05700 CT SCAN	0	41, 673		1, 924	30, 159	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	49, 398 139, 555		985 2, 627	16, 637 65, 757	1
60.00	06000 LABORATORY	0	362, 622		9, 206		
60.01	06001 ONCOLOGY	0	0	0	4, 209	53, 634	
60.02 65.00	06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	0	0 123, 357	0 123, 357	0 5, 840	0 74, 496	60.02 65.00
66.00	06600 PHYSI CAL THERAPY	0	24, 394		7,649		
69.00	06900 ELECTROCARDI OLOGY	0	220, 242	220, 242	3, 417	39, 957	69.00
	06901 CARDI AC REHAB	0	35, 913		771	8, 311	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	291, 816	1
00.00	OUTPATIENT SERVICE COST CENTERS	0	105 540	105 540	1 010	25.077	
	09000 CLINIC 09100 EMERGENCY		100,010		1, 213 33, 622		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0	,		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	114, 911	114, 911	4, 409	43, 679	95.00
	SPECIAL PURPOSE COST CENTERS				1, 10,		70100
113.00 118.00	11300 INTEREST EXPENSE		10 010 005	10,010,005	210 150	2 710 0/2	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	12, 018, 825	12, 018, 825	210, 159	2, 718, 863	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36, 799	36, 799	118	2, 418	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19201 PACT REV PHYSICIANS 19202 VISITOR MEALS	0		0	1, 872 0		192. 01 192. 02
	19203 GREAT BEGI NNI NGS/MATERNAL	0	0	0	413		192.03
	19204 LI FELI NE	0	0	0	0		192.04
	19205 OWNED PROPERTIES 19206 UROLOGY	0		0	0 3, 538		192. 05 192. 06
	19207 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0,000		192.07
	19211 PARI SH NURSI NG	0	0	0	238	2, 509	192.08
	19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS	0	0	0	0		192. 09 192. 10
	19208 MGH EMERGENCY PHYSICIANS	0	0	0	0		192.10
192.12	19209 LUNG CENTER	0	0	0	2, 605	26, 544	192.12
	19213 MGH EXPRESS	0	0	0	3, 909		192.13
	19210 MGH PHYS PRACT MGMT 19215 MGH MARI ON SURGEONS			0	4, 716 6, 586		192. 14 192. 15
	19216 MGH MGH MED ONC	0	0	0	4, 786		
	19217 MGH FMC SOUTH	0	0	0	7, 580		192.17
	19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION			0	1, 302 2, 643		192. 18 192. 19
	1 1 1	. 0	. 0	, v	2,010		

Health Finar	ncial Systems	MARION GENER	AL HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	DF CAPITAL RELATED COSTS	_	Provider CC	CN: 15-0011		eriod: com 07/01/2019	Worksheet B Part II Date/Time Pre 11/20/2020 1:	pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal		EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI V E & GENERAL	
		0	1.00	2A		4.00	5.00	
	NONPAID WORKERS	C	-		0	0		193.00
	MGH FMC NORTHWOOD	C			0	3, 731	39, 237	
	MGH FMC GAS CITY	C			0	2, 132	25, 231	
	MGH HOSPITALISTS	C	0		0	12, 399	124, 708	
	MGH MAR FAM PRACT	C	0		0	9, 432	103, 782	
	MGH FMC SWAYZEE	C	0		0	732		193.05
	MGH PEDIATRIC CTR	0	0		0	2, 764	33, 867	
	MGH SPECIALTY PHYS		0		0	914		193.07
	MGH FMC CONVERSE		0		0	885	11, 326	•
	MGH UPLAND HEALTH		0		0	4, 631	56, 409	
	MGH MGH WOMENS CTR MGH MGH PSYCHLATRY		0		0	0		193. 10 193. 11
193. 12 19312			0		0	8, 183	95, 353	
	MGH RIVER VIEW BLDG		0		0	o, 163 0		193.12
	MGH NEONATOLOGY		0		0	0	25, 298	
	MGH WOUND CARE		0		0	82		193.18
	HEART FAILURE CLINIC		0		0	137		194.00
194.0107950			0		0	0		194.01
	MENTAL HEALTH		0		0	0		194.02
194.0307952	ADVERTI SI NG	0	0		0	463	6, 965	194.03
194.0407953	MGH WORK SOLUTIONS	0	0		0	2, 160	28, 724	194.04
194.0507954	MGH TAYLOR UNIVERSITY	C	0		0	376	3, 751	194.05
194.0607955	OPIOID IMPL GRANT	C	0		0	180	6, 334	194.06
194.0707956	ASTHMA GRANT	C	0		0	13	165	194.07
194.0807957	MGH SMMP BLDG	C	0		0	0	0	194.08
	MGH AMBUCARE BLDG	C	0		0	0		194.09
	MGH 106 LYONS BLDG	C	0		0	0		194.10
194. 11 07960		C	0		0	0		194.11
194. 12 07961		C	0		0	0		194.12
194. 13 07969		C	0		0	0		194.13
194.14 07964		0	0		0	0		194.14
	TOBACCO GRANT	0	0		0	152		194.15
	HRSA NETWORK DEV PLANNING		0		0	8		194.16
	HRSA OPIOID PLANNING		0		0	57		194.17
194. 18 07962	RURAL QI GRANT		0		0	0 92		194. 18 194. 19
200.00	Cross Foot Adjustments				0	92	3, 205	200.00
200.00	Negative Cost Centers		0		0	0	0	200.00
202.00	TOTAL (sum lines 118 through 201)	C	12,055,624	12,055,6	24	299, 988		
202.00		1	1 12,000,024	1 12,000,0		277,700	0,700,072	1-02.00

	Financial Systems TION OF CAPITAL RELATED COSTS	MARI ON GENERAL	Provi der CC		Period:	u of Form CMS-2 Worksheet B	2552-10
					From 07/01/2019 To 06/30/2020	Part II Date/Time Pre 11/20/2020 1:	pared:
	Cost Center Description	MAINTENANCE &	CAFETERIA	CAFETERI A	OPERATION OF	LAUNDRY &	17 pm
	· ·	REPAIRS 6.00	6.01	6.02	PLANT 7.00	LINEN SERVICE 8.00	
	GENERAL SERVICE COST CENTERS	0.00	0.01	0.02	7.00	8.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	0					6.00
6. 01	00601 CAFETERI A	0	178, 661				6. 01
6.02 7.00	00602 CAFETERIA 00700 OPERATION OF PLANT	0	173, 576 0	173, 576 5, 111			6.02 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	5, 11		98, 944	8.00
9.00	00900 HOUSEKEEPI NG	0	0	(0	9.00
10.00 13.00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON	0	0	42 2, 688		39 0	10.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	2,080		37	14.00
	01500 PHARMACY	0	0	9, 096		0	15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0		420.041	20.020	
30.00 31.00	03100 INTENSIVE CARE UNIT	0	0	25, 643 7, 458		20, 830 4, 229	
40.00	04000 SUBPROVI DER – I PF	0	0	(0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	4, 436	5 138, 480	2, 209	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0	4, 351		0	42.00 43.00
101 00	ANCI LLARY SERVICE COST CENTERS	· ·		1,00	· · · · · ·		
	05000 OPERATING ROOM	0	0	15, 100		14, 839	
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	0	(12, 102	-	0 6, 769	51.00 54.00
57.00	05700 CT SCAN	0	0	2, 263		3, 430	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 159	25, 774	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	2,875		980 0	59.00 60.00
60.00	06001 ONCOLOGY	0	0	11, 593		537	60.00
60. 02	06002 RADI ATI ON ONCOLOGY	0	0	(0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	5, 404		727	65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	0	3, 103 4, 504		2, 400 726	66.00 69.00
69.01	06901 CARDI AC REHAB	0	ō	77		0	69.01
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	(- -	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0	(-	0	72.00
70.00	OUTPATIENT SERVICE COST CENTERS		0				/0.00
90.00	09000 CLINIC	0	0	1,432		400	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	20, 765	5 159, 949	37, 196	91.00 92.00
92.00	09201 OBSERVATION BEDS (DISTINCT PART)	0	о	(0 0	0	
	OTHER REIMBURSABLE COST CENTERS	1	-				
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	6, 366	59, 957	3, 108	95.00
113.00	11300 I NTEREST EXPENSE						113.00
118.00		0	173, 576	147, 409	2, 778, 036	98, 456	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	0	125	5 19, 201	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	(192.00
	19201 PACT REV PHYSICIANS	0	0	1, 662	2 0		192.01
	19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL	0	5,085	(192.02 192.03
	19204 LI FELI NE	0	0	(192.04
192.05	19205 OWNED PROPERTIES	0	0	(0 0	0	192.05
	19206 UROLOGY 19207 PHYSI CLANS' PRI VATE OFFI CES	0	0	3, 11	0		192.06 192.07
	19207 PHYSICIANS PRIVATE OFFICES	0	0	337			192.08
192.09	19212 BI OTERRORI SM GRANT	0	0	(0	0	192.09
	19214 BREAST PUMPS	0	0				192.10
	19208 MGH EMERGENCY PHYSICIANS 19209 LUNG CENTER	0	0	1, 598			192.11 192.12
	19213 MGH EXPRESS	0	o	., 570			192.13
	19210 MGH PHYS PRACT MGMT	0	0	7,657	0		192.14
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	0	0	4, 219			192. 15 192. 16
	19217 MGH MGH MED ONC	0	0				192.10
192.18	19218 MGH FAIRM MED ASSOC	0	0	(0 0	5	192.18
	19219 MGH FMC MARI ON	0	0	2, 812	2 0		192.19
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD	0	0				193. 00 193. 01
	19302 MGH FMC GAS CITY	0	0	(193.02
193.02		0	9	,	9		193.03

Health Financial Systems	MARI ON GENERA	L HOSPI TAL		In Lie	u of Form CMS-2552	2-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0011	Peri od:	Worksheet B	
				From 07/01/2019	Part II	
				To 06/30/2020		
					11/20/2020 1:17	pm
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS	(01	(00	PLANT	LINEN SERVICE	
193.04 19304 MGH MAR FAM PRACT	6.00	6.01	6.02	0 0	8.00	2 0 1
	0	0		-		
193. 05 19305 MGH FMC SWAYZEE	0	0	2.4	0 0	5 193	
193. 06 19306 MGH PEDIATRIC CTR	0	0	2,4		10 193	
193.07 19307 MGH SPECIALTY PHYS	0	0	8	32 0	5 193	
193. 08 19308 MGH FMC CONVERSE	0	0		0 0	19 193	
193.09 19309 MGH UPLAND HEALTH	0	0		0 0	174 193	
193.1019310 MGH MGH WOMENS CTR	0	0		0 0	0 193	
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0 0	0 193	
193. 12 19312 OB/GYN	0	0		0 0	0 193	
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0 193	
193.16 19316 MGH NEONATOLOGY	0	0		0 0	0 193	
193.18 19318 MGH WOUND CARE	0	0		0 0	0 193	
194.0007963 HEART FAILURE CLINIC	0	0		0 0	0 194	
194. 01 07950 MOW	0	0		0 0	0 194	
194.0207951 MENTAL HEALTH	0	0		0 0	0 194	4. 02
194. 03 07952 ADVERTI SI NG	0	0	5	77 0	0 194	4.03
194.0407953 MGH WORK SOLUTIONS	0	0		0 0	15 194	4.04
194.0507954 MGH TAYLOR UNIVERSITY	0	0		0 0	0 194	4.05
194.06079550PIOLDIMPL GRANT	0	0	3	67 0	0 194	4.06
194.0707956 ASTHMA GRANT	0	0		14 0	0 194	4.07
194.0807957 MGH SMMP BLDG	0	0		0 0	0 194	4.08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0	0 194	4.09
194.1007959 MGH 106 LYONS BLDG	0	0		0 0	0 194	4.10
194. 11 07960 FAI RMOUNT	0	0		0 0	0 194	4.11
194. 12 07961 GAS CI TY	0	0		0 0	0 194	4.12
194. 13 07969 LYONS	0	0		0 0	0 194	4.13
194. 14 07964 WABASH	0	0		0 0	0 194	4.14
194. 15 07965 TOBACCO GRANT	0	0	2	04 0	0 194	4.15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0		11 0	0 194	
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0		72 0	0 194	
194. 18 07962 ECHO GRANT	0	0		0 0	0 194	
194. 19 07968 RURAL QI GRANT	0	0	1	64 0	0 194	
200.00 Cross Foot Adjustments	0	0				D. 00
201.00 Negative Cost Centers	0	0		0 0	0 201	
202.00 TOTAL (sum lines 118 through 201)	0	178, 661	173, 5	-		
	i oj	170,001	1,5,5		, , , , , , , , , , , , , , , , , , , ,	00

Heal th	Financial Systems	MARI ON GENERA	L HOSPI TAL		In Lieu	ı of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CO		eriod: 	Worksheet B Part II	
				To		Date/Time Pre	pared:
	Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG	CENTRAL	11/20/2020 1: PHARMACY	17 pm
				ADMI NI STRATI O	SERVICES &		
		9.00	10.00	N 13.00	SUPPLY 14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A						6.01 6.02
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	214 509					8.00
9.00 10.00	01000 DI ETARY	214, 508 3, 074	305, 296				9.00 10.00
13.00	01300 NURSING ADMINISTRATION	961	0	68, 421			13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 803 2, 690	0	0	123, 462 0	272, 776	14.00 15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,090	0	0	0	272,770	15.00
	03000 ADULTS & PEDIATRICS	56, 868	196, 472	16, 423	13, 315	0	30.00
	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	10, 759 0	31, 403 0	4, 776 0	4, 842 0	0 0	31.00 40.00
	04100 SUBPROVI DER – I RF	9, 222	32, 104	2, 841	1, 210	0	41.00
	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	2, 787	0	0	43.00
50.00	05000 OPERATING ROOM	28, 435	0		15, 735	0	50.00
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 12, 104	0		0 2, 421	0	51.00 54.00
	05700 CT SCAN	672	0	0	2,421	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 843 10, 759	0	1, 841 0	4, 842 7, 262	0	59.00 60.00
60.00	06001 ONCOLOGY	0,737	0	0	, 202	0	60.00
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	8, 069 0	0	3, 461 1, 987	2, 421	0	65.00 66.00
69.00	06900 ELECTROCARDI OLOGY	5, 187	0	2, 885	3, 631	0	69.00
	06901 CARDI AC REHAB	5, 764	0	494	0	0	69.01
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0 0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	272, 776	73.00
90, 00	OUTPATIENT SERVICE COST CENTERS	3, 843	0	917	0	0	90.00
91.00	09100 EMERGENCY	43, 036	4, 775		6, 052	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.00 92.01
72.01	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92.01
95.00	09500 AMBULANCE SERVICES	1, 345	0	4, 077	1, 210	0	95.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	211, 434	264, 754	64, 231	62, 941	272, 776	
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	384	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
	19201 PACT REV PHYSICIANS 19202 VISITOR MEALS	0	0	1, 065	0		192. 01 192. 02
	19203 GREAT BEGI NNI NGS/MATERNAL	0	0	325	0		192.02
	19204 LI FELI NE	0	0	0	0	0	192.04
	19205 OWNED PROPERTIES 19206 UROLOGY	0	0	0	0 4, 842		192.05 192.06
	19207 PHYSI CLANS' PRI VATE OFFI CES	769	0	0	4, 042		192.00
	19211 PARI SH NURSI NG	384	0	0	0		192.08
	19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS	0	0	0	0	0	192. 09 192. 10
192.11	19208 MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192. 11
	19209 LUNG CENTER	0	0	0 2, 800	0		192. 12 192. 13
	19213 MGH EXPRESS 19210 MGH PHYS PRACT MGMT	0 1, 537	0	2,800	2, 421 0		192.13
192.15	19215 MGH MARION SURGEONS	0	0	0	7, 262	0	192. 15
	19216 MGH MGH MED ONC	0	0	0			192. 16 192. 17
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	0	0	0	6, 052 0		192.17 192.18
192.19	19219 MGH FMC MARION	0	0	0	3, 631	0	192.19
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD	0	0	0	0 1, 210		193. 00 193. 01
	19302 MGH FMC GAS CITY	0	0	0	1, 210		193.01

Health Financial Systems	MARI ON GENERAL			In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 07/01/2019 To 06/30/2020	Date/Time Pr 11/20/2020 1	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI N	SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193. 03 19303 MGH HOSPI TALI STS	0	0		0 0) 193. 03
193.04 19304 MGH MAR FAM PRACT	0	0		0 7, 262		0 193. 04
193.05 19305 MGH FMC SWAYZEE	0	0		0 1, 210		0 193.05
193.06 19306 MGH PEDIATRIC CTR	0	0		0 1, 210	(0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	() 193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 1, 210	(193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 2,421	(193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0	() 193. 10
193.11 19311 MGH MGH PSYCHLATRY	o	0		0 0	() 193. 11
193. 12 19312 OB/GYN	0	0		0 18, 159		193.12
193. 15 19315 MGH RIVER VIEW BLDG	0	0		0 0		193.15
193. 16 19316 MGH NEONATOLOGY	0	0		0 0		193.16
193. 18 19318 MGH WOUND CARE	0	0		0 0		193.18
194. 00 07963 HEART FAILURE CLINIC	0	0				194.00
194. 01 07950 MOW		10, 708				194.00
194. 02 07951 MENTAL HEALTH	0	29, 834		0 0		194.01
194. 03 07952 ADVERTI SI NG	0	29,034		0 0		194.02
194. 04 07953 MGH WORK SOLUTIONS	0	0		0 2,421		194.03
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 2,421		194.04
	0	0		0 0		
194. 06 07955 OPI OLD I MPL GRANT	0	0		0 0		194.06
194. 07 07956 ASTHMA GRANT	0	0		0 0		194.07
194. 08 07957 MGH SMMP BLDG	0	0		0 0		194.08
194. 09 07958 MGH AMBUCARE BLDG	0	0		0 0		0 194.09
194. 10 07959 MGH 106 LYONS BLDG	0	0		0 0		0 194. 10
194. 11 07960 FAI RMOUNT	0	0		0 0		0 194. 11
194. 12 07961 GAS CI TY	0	0		0 0) 194. 12
194. 13 07969 LYONS	0	0		0 0) 194. 13
194. 14 07964 WABASH	0	0		0 0) 194. 14
194.1507965 TOBACCO GRANT	0	0		0 0	() 194. 15
194.1607966 HRSA NETWORK DEV PLANNING	0	0		0 0) 194. 16
194.17 07967 HRSA OPIOID PLANNING	0	0		0 0	() 194. 17
194.18 07962 ECHO GRANT	0	0		0 0	() 194. 18
194.1907968 RURAL QI GRANT	0	0		0 0	() 194. 19
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 20	214, 508	305, 296	68, 42	123, 462	272, 776	1202 00

	Financial Systems TION OF CAPITAL RELATED COSTS	MARION GENERA	NL HOSPITAL Provider CCN	N· 15-0011	In Lieu of Form CM Period: Worksheet E	
LLUCA	THUR OF CALLER LEATED COSTS				From 07/01/2019 Part II	
					To 06/30/2020 Date/Time F 11/20/2020	1:17 pm
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost & Post			
			Stepdown			
	-	24.00	Adjustments			
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
5.00	00500 ADMI NI STRATI VE & GENERAL					5.0
5.00 5.01	00600 MAI NTENANCE & REPAI RS 00601 CAFETERI A					6.0 6.0
5. 02	00602 CAFETERIA					6.0
7.00	00700 OPERATION OF PLANT					7.0
3.00	00800 LAUNDRY & LINEN SERVICE					8.0
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.0 10.0
	01300 NURSI NG ADMI NI STRATI ON					13.0
	01400 CENTRAL SERVICES & SUPPLY					14.0
15.00						15.0
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 433, 266	0	2, 433, 26		30.0
	03100 I NTENSI VE CARE UNI T	586, 596	0	586, 59		31.0
40.00	04000 SUBPROVI DER – I PF	0	0		0	40.0
	04100 SUBPROVIDER - IRF	524, 857	0	524, 85		41.0
	04200 SUBPROVI DER 04300 NURSERY	53, 364	0	53, 36	0	42.0
10.00	ANCI LLARY SERVICE COST CENTERS	00,001		00,00		10.0
	05000 OPERATING ROOM	1, 864, 747	0	1, 864, 74		50.0
	05100 RECOVERY ROOM	1 001 500	0		0	51.0
	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	1, 081, 592 101, 865	0	1, 081, 59 101, 86		54. C
	05800 MAGNETIC RESONANCE IMAGING (MRI)	93, 953	0	93, 95		58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	295, 136	0	295, 13		59. C
	06000 LABORATORY	844, 415	0	844, 41		60.0
50.01 50.02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	58, 380 0	0	58, 38	0	60. C
55.00	06500 RESPI RATORY THERAPY	288, 139	0	288, 13	99	65.0
66.00	06600 PHYSI CAL THERAPY	126, 655	0	126, 65		66.0
	06900 ELECTROCARDI OLOGY	395, 465	0	395, 46		69.0
	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	70, 762 0	0	70, 76	0	69. C
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	72.0
73.00	07300 DRUGS CHARGED TO PATI ENTS	564, 592	0	564, 59	2	73.0
90.00	OUTPATIENT SERVICE COST CENTERS	249, 333	0	249, 33	2	90.0
	09100 EMERGENCY	249, 333 850, 540	0	249, 33 850, 54		90.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	000,010	0	000701		92.0
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	92.0
	OTHER REIMBURSABLE COST CENTERS	239, 062	0	239, 06	2	05 0
75.00	SPECIAL PURPOSE COST CENTERS	239,002	U	239,00	02	95.0
113.00	11300 I NTEREST EXPENSE					113.0
118.00		10, 722, 719	0	10, 722, 71	9	118. 0
00 00	NONREIMBURSABLE COST CENTERS	59, 045	0	50.04	5	190. 0
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	59,045	0	59, 04	0	190.0
92.01	19201 PACT REV PHYSICIANS	25, 560	0	25, 56		192.0
	19202 VI SI TOR MEALS	5, 085	О	5, 08		192.0
	19203 GREAT BEGI NNI NGS/MATERNAL	4, 358	0	4, 35		192.0
	19204 LI FELI NE 19205 OWNED PROPERTI ES	0 9, 533		9, 53	0	192. C 192. C
92.06	19206 UROLOGY	52, 445	0	52, 44		192.0
92.07	19207 PHYSI CLANS' PRI VATE OFFI CES	769	О	76	9	192. (
	19211 PARI SH NURSI NG	3, 468	0	3,46	8	192.0
	19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS	0	0		0	192. (192. 1
	19208 MGH EMERGENCY PHYSI CI ANS	0	0		Ō	192. ⁻
92.12	19209 LUNG CENTER	30, 747	0	30, 74		192. ⁻
	19213 MGH EXPRESS	52, 759	0	52, 75		192.
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	73, 945 84, 364	0	73, 94 84, 36		192. ⁻ 192. ⁻
		04, 304	U			
92.15		52.758	ol	52.75	8	192.1
192. 15 192. 16	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	52, 758 101, 144	0 0	52, 75 101, 14		
192. 15 192. 16 192. 17 192. 18	19216 MGH MGH MED ONC		0 0 0		14 18	192. 1 192. 1 192. 1 192. 1 192. 1

Health Financial Systems	MARION GENERA	AL HOSPI TAL			In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC			eriod: com 07/01/2019 o 06/30/2020	Worksheet B Part II Date/Time Prepared: 11/20/2020 1:17 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24.00	25.00	26.00			
193.01 19301 MGH FMC NORTHWOOD	44, 178	0	44,	178		193.01
193.02 19302 MGH FMC GAS CITY	28, 578	0	28,	578		193.02
193. 03 19303 MGH HOSPI TALI STS	137, 107	0	137,	107		193.03
193.04 19304 MGH MAR FAM PRACT	120, 558	0	120,	558		193.04
193.05 19305 MGH FMC SWAYZEE	10, 444	0	10,	444		193.05
193.06 19306 MGH PEDIATRIC CTR	40, 256	0	40,	256		193.06
193.07 19307 MGH SPECIALTY PHYS	11, 406	0	11,			193.07
193.08 19308 MGH FMC CONVERSE	13, 440	0	13,			193.08
193.09 19309 MGH UPLAND HEALTH	63, 635	0	63,			193.09
193.1019310 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	121, 695	0	121,	695		193.12
193. 15 19315 MGH RIVER VIEW BLDG	,	0	,	0		193.15
193. 16 19316 MGH NEONATOLOGY	25, 298	0	25,	-		193.16
193. 18 19318 MGH WOUND CARE	900	0		900		193.18
194. 00 07963 HEART FAILURE CLINIC	1, 824	0		824		194.00
194. 01 07950 MOW	10, 708	0	10,			194.01
194. 02 07951 MENTAL HEALTH	29, 834	0	29,			194.02
194. 03 07952 ADVERTI SI NG	8,005	0		005		194.03
194. 04 07953 MGH WORK SOLUTI ONS	33, 320	0	33,			194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	4, 127	0		127		194.05
194. 06 07955 OPI 0I D I MPL GRANT	6, 881	0		881		194.06
194. 07 07956 ASTHMA GRANT	192	0		192		194.07
194. 08 07957 MGH SMMP BLDG	0	0		0		194.08
194. 09 07958 MGH AMBUCARE BLDG	0	0		0		194.09
194. 10 07959 MGH 106 LYONS BLDG	215	0		215		194.10
194. 11 07960 FAI RMOUNT	0	0		0		194.11
194. 12 07961 GAS CI TY	0	0		0		194.12
194. 13 07969 LYONS	0	0		Ö		194.12
194. 14 07964 WABASH	0	0		0		194.14
194. 15 07965 TOBACCO GRANT	2, 117	0	2	117		194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	348	0		348		194.15
194. 17 07967 HRSA OPI OI D PLANNI NG	348	0		453		194.17
194. 18 07962 ECHO GRANT	3,403	0	3,	+00		194.17
194. 19 07968 RURAL QI GRANT	2 3, 461	0	2	ے 461		194.18
200.00 Cross Foot Adjustments	3,401	0	3,	401 0		200.00
201.00 Negative Cost Centers	0	0		0		200.00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	12, 055, 624	0	12, 055,	0		201.00
202.00 TOTAL (Sum TIMES TTO THEODY I 201)	12,000,024	U U	12, 033,	024		202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MARION GENERA	Provider C		eriod:	u of Form CMS-2 Worksheet B-1	
					rom 07/01/2019 0 06/30/2020	Date/Time Pre	pared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS	Reconciliatio	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	17 pm
		1.00	SALARI ES) 4. 00	5A	5.00	6.00	
	GENERAL SERVICE COST CENTERS						
1.00 4.00 5.00 6.00 6.01 6.02	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00601 CAFETERIA 00602 CAFETERIA	435, 386 10, 834 133, 787 0 4, 857 0	72, 418, 391 14, 809, 986 0 0	-30, 600, 686 0	0	290, 765 4, 857 0	6.01
13.00 14.00	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	92, 295 2, 113 3, 260 6, 692 696 2, 383 3, 070	769, 765 0 19, 193 838, 039 161, 636				8.00 9.00 10.00 13.00 14.00
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	3,070	2, 626, 099	<u> </u>	4, 245, 271	3, 070	15.00
31.00 40.00 41.00 42.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	42, 972 10, 246 0 9, 585 0 0	5, 802, 981 1, 755, 217 0 1, 031, 101 0 1, 033, 128		2, 957, 477 0 2, 273, 925 0	42, 972 10, 246 0 9, 585 0 0	31.00 40.00 41.00 42.00
50.00	ANCI LLARY SERVI CE COST CENTERS	34, 453	1, 164, 752	0	11, 448, 970	34, 453	50.00
54.00 57.00 58.00 59.00 60.00 60.01 60.02	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY 06500 RESPI RATORY THERAPY	0 20, 686 1, 505 1, 784 5, 040 13, 096 0 0 4, 455	0 2, 401, 381 464, 550 237, 810 634, 292 2, 222, 635 1, 016, 265 0 1, 409, 897		0 5, 857, 194 1, 060, 279 584, 913 2, 311, 798 8, 921, 679 1, 885, 616 0 2, 619, 025	0 20, 686 1, 505 1, 784 5, 040 13, 096 0 0 4, 455	54.00 57.00 58.00 59.00 60.00 60.01 60.02
69.00 69.01 71.00 72.00 73.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 00TPATI ENT SERVI CE COST CENTERS	881 7, 954 1, 297 0 0 0	1, 846, 797 824, 962 186, 052 0 0 0		0	881 7, 954 1, 297 0 0 0	69.00 69.01 71.00 72.00
90.00 91.00 92.00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	4, 895 11, 071 0	292, 774 8, 117, 224 0	0	7, 920, 649	4, 895 11, 071 0	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS				4 505 (5)		1
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	4, 150	1, 064, 532	0	1, 535, 604	4, 150	95.00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	434, 057	50, 731, 068		1	1	1
192. 00 192. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PACT REV PHYSICIANS	1, 329 0 0	28, 422 0 451, 936	0		0	190.00 192.00 192.01
192. 03 192. 04	19202 VISITOR MEALS 19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE 19205 OWNED PROPERTIES	0	0 99, 743 0		0 127, 273 0 335, 157	0	192.02 192.03 192.04 192.05
192.06 192.07 192.08	19206 UROLOGY 19207 PHYSI CLANS' PRI VATE OFFI CES 19211 PARI SH NURSI NG	0	854, 173 0 57, 507	0	1, 439, 803 0 88, 222	0 0 0	192.03 192.06 192.07 192.08 192.09
192. 10 192. 11 192. 12 192. 13 192. 14 192. 15	19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS 19208 MGH EMERGENCY PHYSI CI ANS 19209 LUNG CENTER 19213 MGH EXPRESS 19210 MGH PHYS PRACT MGMT 19215 MGH MARI ON SURGEONS		0 0 629, 024 943, 843 1, 138, 540 1, 590, 034	0 0 0	0 0 933, 194 1, 533, 855 2, 104, 827 2, 330, 800	0 0 0 0 0	192. 10 192. 11 192. 12 192. 13 192. 14 192. 15
192.17	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	0 0 0	1, 155, 509 1, 830, 079 314, 290	0	1, 686, 557 3, 076, 535 589, 606	0	192. 16 192. 17 192. 18

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 07/01/2019 o 06/30/2020		pared:
	1				11/20/2020 1:	
	CAPI TAL					
	RELATED COSTS					
Cost Center Description	NEW BLDG &	EMPLOYEE		ADMI NI STRATI V		
	FLXT	BENEFITS	n	E & GENERAL	REPAI RS	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
	FEET)	(GROSS		COST)	FEET)	
	1.00	SALARIES) 4.00	5A	5.00	6.00	
192.19 19219 MGH FMC MARION	0	638, 001	5/(192.19
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193.01 19301 MGH FMC NORTHWOOD	0	900, 669		1, 379, 441	0	193.01
193.02 19302 MGH FMC GAS CITY	0	514, 643			0	193.02
193. 03 19303 MGH HOSPI TALI STS	0	2, 993, 581	c	4, 384, 321	0	193.03
193.04 19304 MGH MAR FAM PRACT	0	2, 277, 228	0	3, 648, 653	0	193.04
193.05 19305 MGH FMC SWAYZEE	0	176, 828	0	298, 713	0	193.05
193. 06 19306 MGH PEDIATRIC CTR	0	667, 259	0	1, 190, 668	0	193.06
193.07 19307 MGH SPECIALTY PHYS	0	220, 706				193.07
193.08 19308 MGH FMC CONVERSE	0	213, 563				193.08
193.09 19309 MGH UPLAND HEALTH	0	1, 118, 094		1		193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0			193.10
193. 11 19311 MGH MGH PSYCHIATRY	0	0	0	-		193.11
193. 12 19312 OB/GYN	0	1, 975, 709				193.12
193. 15 19315 MGH RIVER VIEW BLDG	0	0	-	, o		193.15
193. 16 19316 MGH NEONATOLOGY	0	0	-		-	193.16
193. 18 19318 MGH WOUND CARE	0	19, 758		28, 752		193.18
194. 00 07963 HEART_FAILURE_CLINIC 194. 01 07950 MOW	0	33, 037 0				194.00 194.01
194. 02 07951 MENTAL_HEALTH	0	0		-		194.01
194. 03 07952 ADVERTI SI NG	0	111, 868	-	-		194.02
194. 04 07953 MGH WORK SOLUTI ONS	0	521, 448				194.03
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	90, 826		.,		194.05
194. 06 07955 OPI OLD I MPL GRANT	0	43, 432				194.06
194. 07 07956 ASTHMA GRANT	0	3, 115				194.07
194.0807957 MGH SMMP BLDG	0	0				194.08
194.0907958 MGH AMBUCARE BLDG	0	0	(c	0 0	0	194.09
194.1007959 MGH 106 LYONS BLDG	0	0	(c	7, 573	0	194.10
194. 11 07960 FAI RMOUNT	0	0	0	0 0	0	194.11
194. 12 07961 GAS_CI TY	0	0	0	0 0	0	194.12
194. 13 07969 LYONS	0	0	C	0 0		194.13
194.14 07964 WABASH	0	0	C	0 0		194.14
194. 15 07965 TOBACCO GRANT	0	36, 658				194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	1, 934				194.16
194. 17 07967 HRSA OPI OI D PLANNI NG	0	13, 652				194.17
194. 18 07962 ECHO GRANT	0	0	0			194.18
194. 19 07968 RURAL QI GRANT	0	22, 214	C	112, 671	0	194.19
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00 201.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	12, 055, 624	16, 831, 540		30, 600, 686	_	201.00
Part I)	12,033,024	10, 031, 340		30, 000, 000		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	27.689508	0. 232421		0. 231128	0. 000000	203.00
204.00 Cost to be allocated (per Wkst. B,		299, 988		3, 765, 872		204.00
Part II)		,				
205.00 Unit cost multiplier (Wkst. B, Part		0. 004142		0. 028444	0. 000000	205.00
11)						
206.00 NAHE adjustment amount to be allocated						206.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						
			•	1		

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENERAL	L HOSPITAL Provider C	CN: 15-0011 P	eriod:	u of Form CMS-2 Worksheet B-1	
				rom 07/01/2019 o 06/30/2020		
Cost Center Description	CAFETERI A (MEALS SERVED)	CAFETERI A (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	11/20/2020 1: HOUSEKEEPI NG (HOURS OF SERVI CE)	<u>17 pm</u>
	6. 01	6.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						1.00 4.00 5.00
6.00 00600 MAI NTENANCE & REPAIRS 6.01 00601 CAFETERIA 6.02 00602 CAFETERIA 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 13.00 01300 NURSI NG ADMI NI STRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	215, 484 209, 351 0 0 0 0 0 0 0 0 0	1, 299, 971 38, 279 0 314 20, 128 8, 590 68, 122	193, 613 2, 113 3, 260 6, 692 696 2, 383	635, 826 0 253 0 238	58, 058 832 260 1, 300 728	$\begin{array}{c} 6.\ 00\\ 6.\ 01\\ 6.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	0 0	192, 059 55, 857 0	10, 246	27, 177	15, 392 2, 912 0	
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0	33, 226 0	9, 585 0	14, 198 0	2, 496 0 0	41.00 42.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	32, 586	0	0	0	43.00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 0 0	113, 086 0 90, 638	0	0	7, 696 0 3, 276	51.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	0 0 0	16, 950 8, 677 21, 530	1, 784	0	182 0 1, 040	57.00 58.00 59.00
60. 00 06000 LABORATORY 60. 01 06001 ONCOLOGY 60. 02 06002 RADI ATI ON ONCOLOGY	0	86, 821 0 0	13, 096 0	0 3, 449	2, 912 0 0	60.00 60.01 60.02
65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0 0 0	40, 476 23, 239 33, 732	4, 455 881	4, 674 15, 425	2, 184 0 1, 404	65.00 66.00
69. 01 06901 CARDI AC REHAB 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0 0 0	5, 772 0 0 0	0	0 0	1, 560 0 0 0	71.00 72.00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	10, 723	1		1, 040	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	155, 515			11, 648 0	92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	0	0	0	0	92.01
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	47, 680	4, 150	19, 972	364	95.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	209, 351	1, 104, 000	192, 284	632, 698	57, 226	113.00 118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0 0	936 0	1, 329 0			190.00 192.00
192. 01 19201 PACT_REV_PHYSICIANS 192. 02 19202 VI SI TOR_MEALS 192. 03 19203 GREAT_BEGI NNI NGS/MATERNAL	0 6, 133	12, 449 0	0	0	0	192.01 192.02 192.03
192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES	0	0		0	0 0	192. 04 192. 05
192. 06 19206 UROLOGY 192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19211 PARI SH NURSI NG	0 0 0	23, 299 0 2, 523	0	0 0 0	208	192.06 192.07 192.08
192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS 192. 11 19208 MGH EMERGENCY PHYSI CLANS	0 0 0	0 0 0	000000000000000000000000000000000000000	0 0 0	0 0	192.09 192.10 192.11
192.12 192.09 LUNG CENTER 192.13 19213 MGH EXPRESS 192.14 19210 MGH PHYS PRACT MGMT 192.15 19215 MGH MARION SURGEONS	0 0 0	11, 965 0 57, 344 31, 599	0	0 0 1, 061 0	0 416	192. 12 192. 13 192. 14 192. 15
192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC 192. 19 19219 MGH FMC MARI ON	0 0 0	0 0 0 21, 062	0 0 0	0 19 29 0	0 0 0	192. 16 192. 17 192. 18 192. 19
193. 00 19300 NONPAI D WORKERS 193. 01 19301 MGH FMC NORTHWOOD	0	0	0	0	0	193. 00 193. 01

lealth Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENERA	Provider C	CN: 15-0011	Peri od:	u of Form CMS-2 Worksheet B-1	
				From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/20/2020 1:	
Cost Center Description	CAFETERIA	CAFETERI A	OPERATION 0	F LAUNDRY &	HOUSEKEEPING	
	(MEALS	(HOURS	PLANT	LINEN SERVICE	(HOURS OF	
	SERVED)	WORKED)	(SQUARE	(POUNDS OF	SERVICE)	
			FEET)	LAUNDRY)		
	6. 01	6.02	7.00	8.00	9.00	
193.02 19302 MGH FMC GAS CITY	0	0		0 32		193.02
193. 03 19303 MGH HOSPITALISTS	0	0		0 0		193.03
193. 04 19304 MGH MAR FAM PRACT	0	0		0 524		193.04
193. 05 19305 MGH FMC SWAYZEE	0	0		0 30		193.05
193. 06 19306 MGH PEDIATRIC CTR	0	18, 014		0 66		193.06 193.07
193.07 19307 MGH SPECIALTY PHYS 193.08 19308 MGH FMC CONVERSE	0	6, 230 0		0 33 0 124		193.07
193. 09 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH	0	0				193.08
193. 10 19310 MGH MGH WOMENS CTR	0	0		0 1, 115 0 0		193.09
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0 0		193.10
193. 12 19312 OB/GYN		0		0 0		193.11
193. 15 19315 MGH RIVER VIEW BLDG	0	0		0 0		193.12
193. 16 19316 MGH NEONATOLOGY	0	0		0 0		193.16
193. 18 19318 MGH WOUND CARE	0	0		0 0		193.18
194. 00 07963 HEART FAILURE CLINIC	0	0		0 0		194.00
194. 01 07950 MOW	0	0		0 0		194.01
194. 02 07951 MENTAL HEALTH	0	0		0 0		194.02
194. 03 07952 ADVERTI SI NG	0	4, 320		0 0		194.03
194.04 07953 MGH WORK SOLUTIONS	0	0		0 95	0	194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0		194.05
194.06079550PIOLDIMPL GRANT	0	2, 750		0 0	0	194.06
194.0707956 ASTHMA GRANT	0	107		0 0	0	194.07
194.0807957 MGH SMMP BLDG	0	0		0 0	0	194.08
194.0907958 MGH AMBUCARE BLDG	0	0		0 0	0	194.09
194.1007959 MGH 106 LYONS BLDG	0	0		0 0	0	194.10
194. 11 07960 FAI RMOUNT	0	0		0 0		194.11
194. 12 07961 GAS_CLTY	0	0		0 0		194.12
194. 13 07969 LYONS	0	0		0 0		194.13
194. 14 07964 WABASH	0	0		0 0		194.14
194. 15 07965 TOBACCO GRANT	0	1, 525		0 0		194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	85		0 0		194.16
194. 17 07967 HRSA OPIOID PLANNING	0	538		0 0		194.17
194. 18 07962 ECHO GRANT	0	0		0 0		194.18
194. 19 07968 RURAL QI GRANT	0	1, 225		0 0	0	194.19
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	1 011 000	1 057 547	10 154 0	20 520 (50	2 500 000	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 911, 933	1, 857, 516				
203.00 Unit cost multiplier (Wkst. B, Part I)		1. 428890				•
204.00 Cost to be allocated (per Wkst. B, Part II)	178, 661	173, 576	2, 797, 2	37 98, 944	214, 508	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 829115	0. 133523	14. 4475	68 0. 155615	3. 694719	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

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENER	AL HOSPITAL Provider CO	°N: 15_0011 ₽	In Lie	u of Form CMS-2552-10 Worksheet B-1
Soon ALLSOATION STATISTICAL BASIS				rom 07/01/2019	Date/Time Prepared:
Cost Center Description	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	11/20/2020 1:17 pm
	10.00	13.00	14.00	15.00	
GENERAL SERVI CE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFI TS 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 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	74, 099				1.00 4.00 5.00 6.01 6.01 6.02 7.00 8.00 9.00 10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	800, 120 0	102 0	100	13.00 14.00 15.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF	47, 686 7, 622 0	55, 857 0	4 0	0 0 0	30. 00 31. 00 40. 00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	7, 792 0 0	0	1 0 0	0 0 0	41. 00 42. 00 43. 00
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 60.01 06001 NCOLOGY 65.00 06500 RESPI RATORY 66.00 06600 PHYSI CAL THERAPY 69.00 06900 ELECTROCARDI OLOGY		98, 730 0 0 21, 530 0 40, 476 23, 239 33, 732	6 0 0 2	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 54.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 60.\ 01\\ 60.\ 02\\ 65.\ 00\\ 66.\ 00\\ 69.\ 00\\ \end{array}$
69. 0106901CARDI ACREHAB71. 0007100MEDI CALSUPPLI ESCHARGED TOPATI ENTS72. 0007200I MPL.DEV.CHARGED TOPATI ENTS73. 0007300DRUGSCHARGED TOPATI ENTS0UTPATI ENTSERVI CECOSTCENTERS	0 0 0	5, 772 0 0 0	0 0 0	0 0 0 100	69. 01 71. 00 72. 00 73. 00
90. 00 91. 00 92. 00 92. 01 92. 01	0 1, 159 0	155, 515		0 0 0	90. 00 91. 00 92. 00 92. 01
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	47, 680	1	0	95.00
113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	64, 259	751, 125	52	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. 01 19201 PACT REV PHYSI CI ANS 192. 02 19202 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. 07 19207 PHYSI CI ANS' PRI VATE OFFI CES 192. 08 19211 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS 192. 11 19208 MGH EMERGENCY PHYSI CI ANS 192. 12 19209 LUNG CENTER 192. 13 19213 MGH EXPRESS 192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARI ON SURGEONS			0 0 0 0 0 0 4 0 0 0 0 0 0 0 0 0 0 0 0 0		190.00 192.00 192.01 192.02 192.03 192.04 192.05 192.06 192.07 192.08 192.09 192.10 192.11 192.12 192.13 192.14 192.15
192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC 192. 19 19219 MGH FMC MARI ON 193. 00 19300 NONPAI D WORKERS	0 0 0 0	0 0 0 0	0 5 0 3 0	0 0 0 0 0	192. 16 192. 17 192. 18 192. 19 193. 00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0011	Peri od:	Worksheet B-1	
				From 07/01/2019 To 06/30/2020	Data /Tima Dra	norod.
				To 06/30/2020	Date/Time Pre 11/20/2020 1:	17 pm
Cost Center Description	DI ETARY	NURSI NG	CENTRAL	PHARMACY	11/20/2020 11	
	(MEALS	ADMI NI STRATI O	SERVICES &	(COSTED		
	SERVED)	N	SUPPLY	REQUIS.)		
		(DI RECT	(COSTED			
		NRSING HRS)	REQUIS.)			
	10.00	13.00	14.00	15.00		
193.01 19301 MGH FMC NORTHWOOD	0			1 0		193.01
193.02 19302 MGH FMC GAS CITY	0			1 0		193.02
193. 03 19303 MGH HOSPI TALI STS	0			0 0		193.03
193. 04 19304 MGH MAR FAM PRACT	0	0		6 0 1 0		193.04
193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDIATRIC CTR		0		1 0		193. 05 193. 06
193. 07 19307 MGH SPECIALTY PHYS	0	0		0 0		193.00
193. 08 19308 MGH FMC CONVERSE	0	0		1 0		193.07
193. 09 19309 MGH UPLAND HEALTH	0	0		2 0		193.08
193. 1019310 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		5 0		193.12
193. 15 19315 MGH RIVER VIEW BLDG	0	0 0		0 0		193.15
193. 16 19316 MGH NEONATOLOGY	0	0		0 0		193.16
193. 18 19318 MGH WOUND CARE	0	0		0 0		193.18
194.0007963 HEART FAILURE CLINIC	0	0		0 0		194.00
194.0107950 MOW	2, 599	0		0 0		194.01
194.0207951 MENTAL HEALTH	7, 241	0		0 0		194.02
194. 03 07952 ADVERTI SI NG	0	0		0 0		194.03
194.0407953 MGH WORK SOLUTIONS	0	0		2 0		194.04
194.0507954 MGH TAYLOR UNIVERSITY	0	0		0 0		194.05
194.06079550PIOLD IMPL GRANT	0			0 0		194.06
194.07 07956 ASTHMA_GRANT	0	0		0 0		194.07
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 0 0		194.12 194.13
194. 13 07969 LYONS 194. 14 07964 WABASH	0	0		0 0		194.13
194. 15 07965 TOBACCO GRANT	0	0		0 0		194.14
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0		0 0		194.15
194. 17 07967 HRSA OPI OLD PLANNI NG	0	0		0 0		194.17
194. 18 07962 ECHO_GRANT	0	0		0 0		194.18
194. 19 07968 RURAL QI GRANT	0	0		0 0		194.19
200.00 Cross Foot Adjustments		_		-		200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	1, 271, 080	1, 464, 864	925, 56	6 5, 528, 827		202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	17. 153808	1. 830805	9, 074. 17647	1 55, 288. 270000		203.00
204.00 Cost to be allocated (per Wkst. B,	305, 296	68, 421	123, 46			204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	4. 120110	0. 085513	1, 210. 41176	5 2, 727. 760000		205.00
)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
	I	I I		I.	I	I

Health F	inancial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0011	Peri od:	Worksheet C	
					From 07/01/2019	Part I	
					To 06/30/2020	Date/Time Pre 11/20/2020 1:	ared:
			Title	XVIII	Hospi tal	PPS	<u>17 piii</u>
			intro		Costs	115	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj .		Di sal I owance	iotal ocoto	
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 0	3000 ADULTS & PEDIATRICS	16, 483, 087		16, 483, 08	37 0	16, 483, 087	30.00
31.00 0	3100 INTENSIVE CARE UNIT	4, 726, 611		4, 726, 61	0	4, 726, 611	31.00
	4000 SUBPROVI DER – I PF	0			0 0	0	40.00
41.00 0	4100 SUBPROVI DER – I RF	3, 716, 162		3, 716, 16	52 0	3, 716, 162	41.00
42.00 0	4200 SUBPROVI DER	0			0 0	0	42.00
43.00 0	4300 NURSERY	1, 921, 773		1, 921, 77	73 0	1, 921, 773	43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	16, 908, 518		16, 908, 51	18 0	16, 908, 518	50.00
	5100 RECOVERY ROOM	0			0 0	0	51.00
	5400 RADI OLOGY-DI AGNOSTI C	8, 678, 458		8, 678, 45	58 0	8, 678, 458	54.00
	5700 CT SCAN	1, 438, 201		1, 438, 20	01 0	1, 438, 201	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	826, 063		826, 06		826, 063	1
	5900 CARDI AC CATHETERI ZATI ON	3, 285, 137		3, 285, 13		3, 285, 137	
	6000 LABORATORY	12, 025, 092		12, 025, 09		12, 025, 092	
	6001 ONCOLOGY	2, 324, 362		2, 324, 36		2, 324, 362	1
	6002 RADIATION ONCOLOGY	0			0 0	0	
	6500 RESPI RATORY THERAPY	3, 744, 083	0			3, 744, 083	
	6600 PHYSI CAL THERAPY	3, 354, 987	0	3, 354, 98		3, 354, 987	
	6900 ELECTROCARDI OLOGY	2, 372, 606		2, 372, 60		2, 372, 606	
	6901 CARDI AC REHAB	540, 856		540, 85		540, 856	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
	7200 I MPL. DEV. CHARGED TO PATIENTS	10 150 05(10 150 0	0 0	-	
	7300 DRUGS CHARGED TO PATIENTS	18, 159, 356		18, 159, 35	6 0	18, 159, 356	73.00
	UTPATIENT SERVICE COST CENTERS	1 000 10/		1 000 1/		1 000 10/	
	9000 CLINIC	1, 883, 186		1, 883, 18		.,,	1
	9100 EMERGENCY	11, 811, 168		11, 811, 16		11, 811, 168	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 680, 776		3, 680, 77		3, 680, 776	
	9201 OBSERVATION BEDS (DISTINCT PART) THER REIMBURSABLE COST CENTERS	0			0 0	0	92.01
	9500 AMBULANCE SERVICES	2, 311, 624		2, 311, 62	24 0	2 211 424	95.00
	PECIAL PURPOSE COST CENTERS	2, 311, 024		2, 311, 02	24 0	2, 311, 624	95.00
	1300 INTEREST EXPENSE				1		113.00
200.00	Subtotal (see instructions)	120, 192, 106	0	120, 192, 10)6 0	120, 192, 106	
200.00	Less Observation Beds	3, 680, 776	0	3, 680, 77		3, 680, 776	
201.00	Total (see instructions)	116, 511, 330	0				
202.00		1 110, 511, 550	0	1 110, 511, 50		110, 511, 550	202.00

Health Fina	ancial Systems	MARION GENERA	_ HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION	N OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/20/2020 1:	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	0 ADULTS & PEDIATRICS	14, 516, 394		14, 516, 39	4		30.00
31.00 0310	O INTENSIVE CARE UNIT	5, 957, 576		5, 957, 57	6		31.00
40.00 0400	O SUBPROVI DER – I PF	0			0		40.00
41.00 0410	O SUBPROVI DER – I RF	3, 401, 928		3, 401, 92	8		41.00
42.00 0420	O SUBPROVI DER	0			0		42.00
43.00 0430	O NURSERY	2, 386, 088		2, 386, 08	8		43.00
ANCI	LLARY SERVICE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
	O OPERATING ROOM	31, 101, 252	75, 827, 381	106, 928, 63	3 0. 158129	0. 000000	50.00
51.00 0510	O RECOVERY ROOM	0	0		0 0. 000000	0.000000	
	O RADI OLOGY-DI AGNOSTI C	1, 706, 992	27, 455, 792	29, 162, 78		0.000000	
	O CT SCAN	5, 398, 249	31, 877, 299			0.000000	
	O MAGNETIC RESONANCE IMAGING (MRI)	331, 380	3, 332, 488			0. 000000	
	O CARDI AC CATHETERI ZATI ON	2, 924, 967	6, 153, 343			0. 000000	
	O LABORATORY	3, 695, 025	15,005,416			0. 000000	
	1 ONCOLOGY	38, 975	7, 803, 508			0. 000000	
	2 RADIATION ONCOLOGY	30, 773	7,003,000		0.000000	0. 000000	
	0 RESPIRATORY THERAPY	2, 351, 971	5, 759, 187			0. 000000	
	0 PHYSI CAL THERAPY	4, 531, 306	6, 156, 478			0. 000000	
	0 ELECTROCARDI OLOGY	3, 704, 862	9, 150, 318			0. 000000	
	11 CARDI AC REHAB	3, 704, 802	9, 150, 318 857, 220			0. 000000	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0. 000000	
	0 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000 0 0. 000000	0. 000000	
		6 702 024		04 250 70			
	0 DRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS	6, 723, 934	89, 526, 770	96, 250, 70	0. 188667	0.00000	73.00
	OCLINIC	F 000	2 240 0/1	2 252 0/	0. 800041	0.00000	90.00
	IO EMERGENCY	5,000	2, 348, 861			0.00000	
		11, 698, 307	62, 767, 720			0.00000	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0	8, 171, 988			0.00000	
	OBSERVATION BEDS (DISTINCT PART)	0	0		0 0.000000	0.00000	92.01
	R REIMBURSABLE COST CENTERS						05.00
	0 AMBULANCE SERVICES	0	4, 434, 365	4, 434, 36	0. 521298	0.00000	95.00
	I AL PURPOSE COST CENTERS	I I					
	O INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	100, 474, 206	356, 628, 134	457, 102, 34	0		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	100, 474, 206	356, 628, 134	457, 102, 34	0		202.00

Health Financial Systems	MARION GENERAL	HOSPI TAL	In Lieu	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/20/2020 1:	pared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
40. 00 04000 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	· · ·				1
50.00 05000 OPERATING ROOM	0. 158129				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 297587				54.00
57. 00 05700 CT SCAN	0. 038583				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 225462				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 361867				59.00
60. 00 06000 LABORATORY	0. 643038				60.00
60. 01 06001 0NC0L0GY	0. 296381				60.00
60. 02 06002 RADIATION ONCOLOGY	0. 000000				60.02
65. 00 06500 RESPIRATORY THERAPY	0. 461597				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 313909				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 313909				69.00
69. 01 06901 CARDI AC REHAB	0. 630942				69.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 188667				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 800041				90.00
91.00 09100 EMERGENCY	0. 158611				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 450414				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
OTHER REIMBURSABLE COST CENTERS	· · ·				
95.00 09500 AMBULANCE SERVICES	0. 521298				95.00
SPECIAL PURPOSE COST CENTERS	1				
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health F	inancial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0011	Peri od:	Worksheet C	
					From 07/01/2019	Part I	
					To 06/30/2020	Date/Time Pre 11/20/2020 1:	ared:
			Ti +I	e XIX	Hospi tal	Cost	17 piii
			11.01		Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj.		Di sal I owance	iotal ocoto	
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
11	NPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 0	3000 ADULTS & PEDI ATRI CS	16, 483, 087		16, 483, 08	37 0	16, 483, 087	30.00
31.00 0	3100 INTENSIVE CARE UNIT	4, 726, 611		4, 726, 61	1 0	4, 726, 611	31.00
	4000 SUBPROVI DER – I PF	0			0 0	0	40.00
41.00 0	4100 SUBPROVIDER - IRF	3, 716, 162		3, 716, 16	02 0	3, 716, 162	41.00
42.00 0	4200 SUBPROVI DER	0			0 0	0	42.00
43.00 0	4300 NURSERY	1, 921, 773		1, 921, 77	3 0	1, 921, 773	43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	16, 908, 518		16, 908, 51	8 0	16, 908, 518	50.00
	5100 RECOVERY ROOM	0			0 0	0	
	5400 RADI OLOGY-DI AGNOSTI C	8, 678, 458		8, 678, 45	68 0	8, 678, 458	54.00
	5700 CT SCAN	1, 438, 201		1, 438, 20		1, 438, 201	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	826, 063		826, 06		826, 063	
	5900 CARDI AC CATHETERI ZATI ON	3, 285, 137		3, 285, 13		3, 285, 137	
1	6000 LABORATORY	12, 025, 092		12, 025, 09		12, 025, 092	
	6001 ONCOLOGY	2, 324, 362		2, 324, 36		2, 324, 362	
	6002 RADIATION ONCOLOGY	0			0 0	0	
	6500 RESPI RATORY THERAPY	3, 744, 083	0			3, 744, 083	
	6600 PHYSI CAL THERAPY	3, 354, 987	0	3, 354, 98		3, 354, 987	
	6900 ELECTROCARDI OLOGY	2, 372, 606		2, 372, 60		2, 372, 606	
	6901 CARDI AC REHAB	540, 856		540, 85		540, 856	
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0			0 0	0	
	7200 I MPL. DEV. CHARGED TO PATIENTS	10 150 05(10 150 05	0 0	0	
	7300 DRUGS CHARGED TO PATIENTS	18, 159, 356		18, 159, 35	6 0	18, 159, 356	73.00
	UTPATIENT SERVICE COST CENTERS	1 000 10/		1 000 10		1 000 10/	00.00
	9000 CLINIC	1, 883, 186		1, 883, 18		.,,	
	9100 EMERGENCY	11, 811, 168		11, 811, 16		11, 811, 168	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 680, 776		3, 680, 77		3, 680, 776	
	9201 OBSERVATION BEDS (DISTINCT PART) THER REIMBURSABLE COST CENTERS	0			0 0	0	92.01
	9500 AMBULANCE SERVICES	2, 311, 624		2, 311, 62	24 0	2 211 424	95.00
	PECIAL PURPOSE COST CENTERS	2, 311, 024		2,311,02	4 0	2, 311, 624	95.00
	1300 INTEREST EXPENSE	1					113.00
200.00	Subtotal (see instructions)	120, 192, 106	0	120, 192, 10	0	120, 192, 106	
200.00	Less Observation Beds	3, 680, 776		3, 680, 77		3, 680, 776	
201.00	Total (see instructions)	116, 511, 330					
202.00		110, 511, 550	0	1 110, 511, 55		110, 511, 550	202.00

Health Fin	ancial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATIC	N OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/20/2020 1:	epared: 17 pm
			Ti tl	e XIX	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col.)	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	DO ADULTS & PEDIATRICS	14, 516, 394		14, 516, 39	4		30.00
31.00 0310	DO INTENSIVE CARE UNIT	5, 957, 576		5, 957, 57	6		31.00
40.00 0400	DO SUBPROVI DER – I PF	0			0		40.00
41.00 0410	DO SUBPROVIDER - IRF	3, 401, 928		3, 401, 92	8		41.00
	DO SUBPROVI DER	0			0		42.00
	DO NURSERY	2, 386, 088		2, 386, 08	8		43.00
	LLARY SERVICE COST CENTERS	2/000/000		2/000/00	0		
	DO OPERATING ROOM	31, 101, 252	75, 827, 381	106, 928, 63	3 0. 158129	0, 000000	50.00
	DO RECOVERY ROOM	01,101,202	0,027,001		0 0.000000		
	DO RADI OLOGY-DI AGNOSTI C	1, 706, 992	27, 455, 792			0. 000000	
	DO CT SCAN	5, 398, 249	31, 877, 299	37, 275, 54		0. 000000	
	DO MAGNETIC RESONANCE IMAGING (MRI)	331, 380	3, 332, 488	3, 663, 86		0. 000000	
	DO CARDIAC CATHETERIZATION	2, 924, 967	5, 332, 400 6, 153, 343	9, 078, 31		0. 000000	
	DO LABORATORY						
	DI LABORATORY DI ONCOLOGY	3, 695, 025	15,005,416			0.00000	
		38, 975	7, 803, 508			0.00000	
	D2 RADIATION ONCOLOGY	0	0		0 0.00000	0.00000	
		2, 351, 971	5, 759, 187	8, 111, 15		0.00000	
	DO PHYSI CAL THERAPY	4, 531, 306	6, 156, 478	10, 687, 78		0.00000	
	DO ELECTROCARDI OLOGY	3, 704, 862	9, 150, 318			0.00000	
	D1 CARDI AC REHAB	0	857, 220	857, 22		0. 000000	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	
	DO IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000		
	DO DRUGS CHARGED TO PATIENTS	6, 723, 934	89, 526, 770	96, 250, 70	4 0. 188667	0. 000000	73.00
	PATIENT SERVICE COST CENTERS						
	DO CLINIC	5,000	2, 348, 861	2, 353, 86		0. 000000	
	DO EMERGENCY	11, 698, 307	62, 767, 720	74, 466, 02	7 0. 158611	0. 000000	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	8, 171, 988	8, 171, 98	8 0. 450414	0.00000	92.00
92.01 0920	01 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0. 000000	0.00000	92.01
OTHE	ER REIMBURSABLE COST CENTERS						
95.00 0950	DO AMBULANCE SERVICES	0	4, 434, 365	4, 434, 36	5 0. 521298	0. 000000	95.00
	CIAL PURPOSE COST CENTERS						1
113.001130	DO INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	100, 474, 206	356, 628, 134	457, 102, 34	0		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	100, 474, 206	356, 628, 134	457, 102, 34	o		202.00
				,	- 1		,

31.00 03100 INTENSIVE CARE UNIT 3 40.00 04000 SUBPROVI DER - IPF 2 41.00 04200 SUBPROVI DER - IRF 2 43.00 04300 NURSERY 2 ANCI LLARY SERVICE COST CENTERS 2 ANCI LLARY SERVICE COST CENTERS 2 50.00 05000 OPERATING ROOM 0.000000 51.00 05100 RECOVERY ROOM 0.000000 51.00 05100 RECOVERY ROOM 0.000000 554.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 57.00 05700 CT SCAN 0.000000 5 58.00 065800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 5 59.00 CARDI AC CATHETERI ZATI ON 0.000000 5 60.00 06000 LABORATORY 0.000000 5 60.01 0ACOL GAY 0.000000 6 61.00 06600 PHYSI CAL THERAPY 0.000000 6 65.00 06500 RESPI RATORY THERAPY 0.000000 6 66.00 066000 PHYSI	Heal th	Financial Systems	MARION GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
Cost Center Description PPS Inpatient Ratio PPS Inpatient Ratio PRATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 33 31.00 3300 11.00 3300	COMPUT	ATION OF RATIO OF COSTS TO CHARGES			From 07/01/2019 To 06/30/2020	Part I Date/Time Pre	pared: 17 pm
Ratio Ratio 30.00 O3000 ADULTS & PEDIATRICS 31.00 31.00 O3100 INTENSIVE CARE UNIT 31.00 40.00 O4000 SUBPROVI DER - 1 PF 42.00 41.00 O4100 SUBPROVI DER - 1 RF 42.00 43.00 O4300 NURSERY 42.00 ANCILLARY SERVICE COST CENTERS 50.00 51.00 O5100 OPERATI NG ROOM 0.000000 51.00 O5100 RECOVERY ROM 0.000000 54.00 O5500 CT SCAN 0.000000 55.00 O5500 CT SCAN 0.000000 56.00 O5500 CT SCAN 0.000000 57.00 O5700 CT SCAN 0.000000 58.00 O5800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 59.00 O5900 CARDI AC CATHERIZATI ON 0.000000 59.00 O5900 CARDI AC CATHERIZATI ON 0.000000 60.01 06001 ONCOLOGY 0.000000 60 61.01 06001 ONCOLOGY 0.000000 60 62.00 CABORATORY 0.000000 60 63.00 <				Title XIX	Hospi tal	Cost	
11.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - IPF 41.00 04100 SUBPROVI DER - IRF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS 50.00 05000 APERATI NG ROM 51.00 05100 RECOVERY ROM 0.000000 05400 RADI OLOGY-DI AGNOSTI C 0.000000 05700 CT SCAN 54.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 05900 CARDI AC CATHETERI ZATI ON 0.000000 05900 CARDI AC CATHETERI ZATI ON 0.000000 05900 CARDI AC CATHETERI ZATI ON 0.000000 06000 0.000000 06000 0.000000 06000 0.000000 06000 0.000000 06000 0.000000 06000 0.000000 0600 0.000000 0600 0.000000 0600 0.000000		Cost Center Description					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 31. 00 03100 INTENSI VE CARE UNI T 32. 40. 00 04000 SUBPROVI DER - IPF 42. 41. 00 04100 SUBPROVI DER - IRF 42. 43. 00 043000 NURSERY 44. ANCI LLARY SERVI CE COST CENTERS 44. 50. 00 05000 OPERATI NG ROOM 0.000000 51. 00 05100 RECOVERY ROOM 0.000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 57. 00 05700 CT SCAN 0.000000 58. 00 058000 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 59. 00 058000 MAGNETI C CATHETERI ZATI ON 0.000000 59. 00 058000 CARDI AC CATHETERI ZATI ON 0.000000 60. 01 06001 ADRATORY 0.000000 60. 02 06002 RADI ATI ON ONCOLOGY 0.000000 60. 00 065000 RESPI RATORY THERAPY 0.000000 60. 00 066000 PHYSI CAL THERAPY 0.000000 60. 00 066000 PHYSI CAL THERAPY 0.000000 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 40.00 04000 SUBPROVI DER - 1PF 42.00 04100 SUBPROVI DER 42.00 41.00 04100 SUBPROVI DER 1RF 42.00 04300 NURSERY 42.00 ANCILLARY SERVICE COST CENTERS ANCILLARY SERVICE COST CENTERS 40.000000 50.00 50.00 05000 OPERATING ROOM 0.000000 51.00 51.00 05100 RECOVERY ROOM 0.000000 55.00 53.00 05300 OPERATING ROOM 0.000000 55.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55.00 57.00 05700 CT SCAN 0.000000 55.00 0.000000 55.00 60.00 06900 LABORATORY 0.000000 55.00 0.000000 55.00 60.01 06001 ONCOLOGY 0.000000 66.00 0.0002 66.00 0.000000 66.00 60.00 0.000000 0.000000 66.00 0.000000 66.00 66.00 0.06000 PHYSI CAL THERAPY 0.000000 66.00			11.00		· · · · · · · · · · · · · · · · · · ·		
31.00 03100 INTENSI VE CARE UNI T 33.00 40.00 04000 SUBPROVI DER - I PF 4 41.00 04100 SUBPROVI DER 4 42.00 04200 SUBPROVI DER 4 43.00 04200 SUBPROVI DER 4 43.00 04300 NURSERY 4 ANCI LLARY SERVI CE COST CENTERS 5 0.00000 5 51.00 05100 RECOVERY ROOM 0.000000 5 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.0000000 5 57.00 05700 CT SCAN 0.000000 5 5 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 5 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 5 60.01 06000 LABORATORY 0.000000 5 60.02 RADI ATI ON ONCOLOGY 0.000000 6 61.00 06002 RADI ATI ON ONCOLOGY 0.000000 6 65.00 06500 RESPI RATORY THERAPY 0.000000 6 65.00 06600 PHYSI CAL			1				
40.00 04000 SUBPROVI DER - 1 PF 4 41.00 04100 SUBPROVI DER - 1 RF 4 42.00 04200 SUBPROVI DER 4 43.00 04300 NURSERY 4 ANCI LLARY SERVICE COST CENTERS 4 4 50.00 05000 OPERATI NG ROOM 0.000000 51.00 05100 RECOVERY ROM 0.000000 54.00 05400 RAI OLOGY-DI AGNOSTI C 0.000000 57.00 05700 CT SCAN 0.000000 5 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 5 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 5 60.00 06000 LABORATORY 0.000000 5 60.01 0ACOLLOGY 0.000000 6 61.00 06002 RADI ATI ON ONCOLOGY 0.000000 6 65.00 06500 RESPI RATORY THERAPY 0.000000 6 66.00 06600 PHYSI CAL THERAPY 0.000000 6 67.00 06600 CARDI AC REHAB							30.00
41.00 04100 SUBPROVI DER - I RF 42 42.00 04200 SUBPROVI DER 44 43.00 04300 NURSERY 44 ANCI LLARY SERVI CE COST CENTERS 44 45 50.00 05000 OPERATI NG ROOM 0.000000 51.00 05100 RECOVERY ROOM 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 57.00 05700 CT SCAN 0.000000 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 55 60.01 06001 LABORATORY 0.000000 66 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65.00 06500 RESPI RATORY THERAPY 0.000000 66 66.00 06600 PHYSI CAL THERAPY 0.000000 66 67.00 06600 PHYSI CAL THERAPY 0.000000 66 69.00 06600 PHYSI CAL THERAPY 0.000000 66 69.00 06600 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>							31.00
42.00 04200 SUBPROVI DER 4 43.00 04300 NURSERY 4 ANCI LLARY SERVI CE COST CENTERS 4 50.00 05000 OPERATI NG ROOM 0.000000 5 51.00 05100 RECOVERY ROOM 0.000000 5 54.00 05400 RADI 0L0GY-DI AGNOSTI C 0.000000 5 57.00 05700 CT SCAN 0.000000 5 58.00 05800 MACNETI C RESONANCE I MAGI NG (MRI) 0.000000 5 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 5 60.01 06001 UNCOLOGY 0.000000 5 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 6 61.02 06500 RESPI RATORY THERAPY 0.000000 6 65.00 06500 RESPI RATORY THERAPY 0.000000 6 66.00 06600 PHYSI CAL THERAPY 0.000000 6 67.00 06900 ELECTROCARDI OLOGY 0.000000 6 69.01 06000 ELECTROCARDI OLOGY 0.000000 6 69.01 06900 ELECTROCARDI OLOGY 0.000000 6							40.00
43.00 NURSERY 4 ANCI LLARY SERVI CE COST CENTERS 50.00 50.00 05000 OPERATI NG ROOM 0.000000 51.00 05100 RECOVERY ROOM 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 57.00 05700 CT SCAN 0.000000 55 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 55 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 55 60.01 06000 LABORATORY 0.000000 56 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 56 65.00 06500 RESPI RATORY THERAPY 0.000000 66 66.00 06600 PHYSI CAL THERAPY 0.000000 66 67.00 06900 ELECTROCARDI OLOGY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 67 69.01 06900 ELECTROCARDI OLOGY 0.000000 67 <							41.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 55 51.00 05100 RECOVERY ROOM 0.000000 55 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55 57.00 05700 CT SCAN 0.000000 55 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 55 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 55 60.00 06000 LABORATORY 0.000000 56 60.01 06001 ONCOLOGY 0.000000 56 65.00 06500 RESPI RATORY THERAPY 0.000000 66 65.00 06500 RESPI RATORY THERAPY 0.000000 66 66.00 06600 PHYSI CAL THERAPY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 67 69.01 06900 ELECTROCARDI OLOGY 0.000000 67 69.01 06900 EL							42.00
50.00 05000 OPERATING ROOM 0.000000 55 51.00 05100 RECOVERY ROOM 0.000000 55 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55 57.00 05700 CT SCAN 0.000000 55 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 55 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 55 60.00 06000 LABORATORY 0.000000 56 60.01 06001 ONCOLOGY 0.000000 66 61.02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65.00 065000 RESPI RATORY THERAPY 0.000000 66 66.00 06600 PHYSI CAL THERAPY 0.000000 66 67.00 069001 CARDI AC REHAB 0.000000 66 69.01 069001 CARDI AC REHAB 0.000000 67 69.01 069001 CARDI AC REHAB 0.000000 67 69.01 069001 CARDI AC REHAB 0.000000 67							43.00
51.00 05100 RECOVERY ROOM 0.000000 55 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55 57.00 05700 CT SCAN 0.000000 55 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 55 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 55 60.01 06001 ONCOLOGY 0.000000 56 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65.00 06500 RESPI RATORY THERAPY 0.000000 66 66.00 06600 PHYSI CAL THERAPY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 66 69.01 069001 CARDI AC REHAB 0.000000			1				
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0.000000 55 57. 00 05700 CT SCAN 0.000000 55 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 55 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 55 60. 01 06001 LABORATORY 0.000000 66 60. 02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65. 00 06500 RESPI RATORY THERAPY 0.000000 66 66. 00 06600 PHYSI CAL THERAPY 0.000000 66 69. 01 06900 ELECTROCARDI OLOGY 0.000000 66 71. 00 07100 MEDI CAL SUPPLI ES CHARGE							50.00
57.00 05700 CT SCAN 0.000000 55 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 55 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 55 60.00 06000 LABORATORY 0.000000 55 60.01 06001 ONCOLOGY 0.000000 66 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65.00 06500 RESPI RATORY THERAPY 0.000000 66 66.00 06000 PHYSI CAL THERAPY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 66 69.01 06900 CARDI AC REHAB 0.000000 67 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 77							51.00
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 59 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 60.00 06000 LABORATORY 0.000000 60 60.01 06001 ONCOLOGY 0.000000 60 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 60 65.00 06500 RESPI RATORY THERAPY 0.000000 60 66.00 06600 PHYSI CAL THERAPY 0.000000 60 69.00 06900 ELECTROCARDI OLOGY 0.000000 60 69.01 06901 CARDI AC REHAB 0.000000 60 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 60							54.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 50000 60.00 06000 LABORATORY 0.000000 60000 60.01 06001 ONCOLOGY 0.000000 60000 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 600000 65.00 06500 RESPI RATORY THERAPY 0.000000 6000000 66.00 06600 PHYSI CAL THERAPY 0.000000 600000 69.00 06900 ELECTROCARDI OLOGY 0.000000 6000000 69.01 06901 CARDI AC REHAB 0.000000 600000 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 7000000							57.00
60.00 06000 LABORATORY 0.000000 66 60.01 06001 ONCOLOGY 0.000000 66 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65.00 06500 RESPI RATORY THERAPY 0.000000 66 66.00 06600 PHYSI CAL THERAPY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 66 69.01 06901 CARDI AC REHAB 0.000000 67 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 77	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
60. 01 06001 0NC0L0GY 0.000000 66 60. 02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65. 00 06500 RESPI RATORY THERAPY 0.000000 66 66. 00 06600 PHYSI CAL THERAPY 0.000000 66 69. 00 06900 ELECTROCARDI OLOGY 0.000000 66 69. 01 06901 CARDI AC REHAB 0.000000 66 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 77	59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 02 06002 RADI ATI ON ONCOLOGY 0.000000 66 65. 00 06500 RESPI RATORY THERAPY 0.000000 66 66. 00 06600 PHYSI CAL THERAPY 0.000000 66 69. 00 06900 ELECTROCARDI OLOGY 0.000000 66 69. 01 06901 CARDI AC REHAB 0.000000 66 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 77	60.00	06000 LABORATORY	0. 000000				60.00
65.00 06500 RESPI RATORY THERAPY 0.000000 66 66.00 06600 PHYSI CAL THERAPY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 66 69.01 06901 CARDI AC REHAB 0.000000 66 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 77	60.01	06001 ONCOLOGY	0. 000000				60.01
66.00 06600 PHYSI CAL THERAPY 0.000000 66 69.00 06900 ELECTROCARDI OLOGY 0.000000 66 69.01 06901 CARDI AC REHAB 0.000000 66 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 77	60.02	06002 RADIATION ONCOLOGY	0. 000000				60.02
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 66 69. 01 06901 CARDI AC REHAB 0. 000000 66 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 77	65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
69. 01 06901 CARDI AC REHAB 0. 000000 6 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 7	66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 000000 77	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 77	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 77	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATI ENT SERVI CE COST CENTERS		OUTPATIENT SERVICE COST CENTERS	· · · ·				
90. 00 09000 CLINIC 0. 000000 99	90.00	09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY 0.000000 95	91.00	09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 9	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000				92.00
							92.01
OTHER REIMBURSABLE COST CENTERS							
			0,000000				95.00
SPECIAL PURPOSE COST CENTERS			· · · · · · · · · · · · · ·				
							113.00
							200.00
							201.00
							202.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provider C		Period:	Worksheet D	
				From 07/01/2019 To 06/30/2020		narad
				10 00/30/2020	11/20/2020 1:	
		Title	e XVIII	Hospi tal	PPS	<u>,, but</u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	2, 433, 266		2, 433, 26		167.09	
31.00 INTENSIVE CARE UNIT	586, 596		586, 59	6 3, 206	182.97	
40.00 SUBPROVIDER - IPF	0	0		0 0	0.00	
41.00 SUBPROVIDER – IRF	524, 857	0	524, 85	7 2, 665	196.94	
42.00 SUBPROVI DER	0	0	(0 0	0.00	
43.00 NURSERY	53, 364		53, 36		33.02	
200.00 Total (lines 30 through 199)	3, 598, 083		3, 598, 08	3 22, 050		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	6, 00	col. 6) 7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
30. 00 ADULTS & PEDIATRICS	4, 589	766, 776				30.00
31. 00 I NTENSI VE CARE UNI T	851	155, 707				31.00
40. 00 SUBPROVIDER - IPF	0	100,707				40.00
41. 00 SUBPROVIDER – IRF	2,062	406, 090				41.00
42. 00 SUBPROVIDER	2,002	100,070				42.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	7, 502	1, 328, 573				200.00
	, , , , , , , , , , , , , , , , , , , ,					

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/20/2020 1:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	1, 864, 747	106, 928, 633			179, 292	50.00
51.00 05100 RECOVERY ROOM	0		0.00000		Ŭ Ŭ	
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 081, 592			699, 374	25, 938	54.00
57.00 05700 CT SCAN	101, 865	37, 275, 548	0. 00273	2, 530, 471	6, 916	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	93, 953	3, 663, 868	0. 02564	154, 628	3, 965	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	295, 136	9, 078, 310	0. 03251	0 953, 463	30, 997	59.00
60. 00 06000 LABORATORY	844, 415	18, 700, 441	0. 04515	55 1, 489, 358	67, 252	60.00
60. 01 06001 ONCOLOGY	58, 380	7, 842, 483	0.00744	20, 043	149	60.01
60. 02 06002 RADIATION ONCOLOGY	0	0	0. 00000	0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	288, 139	8, 111, 158	0. 03552	839, 086	29, 808	65.00
66. 00 06600 PHYSI CAL THERAPY	126, 655	10, 687, 784	0. 01185	60 822, 346	9, 745	66.00
69.00 06900 ELECTROCARDI OLOGY	395, 465	12, 855, 180	0. 03076	1, 711, 157	52, 640	69.00
69. 01 06901 CARDI AC REHAB	70, 762	857, 220	0. 08254	8 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	564, 592	96, 250, 704	0.00586	2, 477, 557	14, 533	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	249, 333	2, 353, 861	0. 10592	4, 753	503	90.00
91.00 09100 EMERGENCY	850, 540			4, 640, 847	53,008	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	543, 364	8, 171, 988	0.06649		0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		1	0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS				- 1		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	7, 428, 938	426, 405, 989		26, 624, 183	474, 746	

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 07/01/2019 To 06/30/2020	Worksheet D Part III Date/Time Pre 11/20/2020 1:	epared: 17 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	School	School	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0	0	42.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	-				
31.00 03100 INTENSIVE CARE UNIT		0				
40. 00 04000 SUBPROVI DER – I PF	0	, s		0 0.00		
41.00 04100 SUBPROVI DER – I RF	0	0	2,66			
42. 00 04200 SUBPROVI DER	0	0		0 0.00		
43. 00 04300 NURSERY		0				
200.00 Total (lines 30 through 199)		0	22, 05	50	7, 502	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	-					0.0.65
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
	0	1				42.00
42. 00 04200 SUBPROVI DER	-					
42.00 04200 SUBPROVIDER 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0011	Period: From 07/01/2019 To 06/30/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS			_			
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 0NC0L0GY	0	0		0 0	0	60.01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		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			I			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
			•	1		

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019		norod.
				To 06/30/2020	Date/Time Pre 11/20/2020 1:	17 nm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-	1			
50.00 O5000 OPERATING ROOM	0	0		0 106, 928, 633		
51.00 05100 RECOVERY ROOM	0	0		0 0	0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 29, 162, 784		
57.00 05700 CT SCAN	0	0		0 37, 275, 548		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 3, 663, 868		•
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 9, 078, 310		•
60. 00 06000 LABORATORY	0	0		0 18, 700, 441		•
60. 01 06001 ONCOLOGY	0	0		0 7, 842, 483		
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 8, 111, 158		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 687, 784		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 12, 855, 180		•
69. 01 06901 CARDI AC REHAB	0	0		0 857, 220		•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 96, 250, 704	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	1		1			-
90. 00 09000 CLINIC	0	0		0 2, 353, 861		
91.00 09100 EMERGENCY	0	0		0 74, 466, 027		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 8, 171, 988		
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0.00000	92.01
OTHER REIMBURSABLE COST CENTERS	1			-		
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 426, 405, 989		200.00

Health Financial Systems	MARI ON GENERAL	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 07/01/2019 To 06/30/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				1		
50.00 05000 OPERATING ROOM	0. 000000	10, 281, 100		0 17, 149, 713	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	699, 374		0 6, 472, 764	0	54.00
57.00 05700 CT SCAN	0. 000000	2, 530, 471		0 7, 785, 088	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	154, 628		0 963, 980	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	953, 463		0 2, 224, 224	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 489, 358		0 2, 091, 341	0	60.00
60. 01 06001 ONCOLOGY	0. 000000	20, 043		0 2, 690, 646	0	60.01
60. 02 06002 RADIATION ONCOLOGY	0. 000000	0		0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	0. 000000	839, 086		0 1, 650, 915	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	822, 346		0 96, 131	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	1, 711, 157		0 2, 500, 522	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0 435, 900	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	2, 477, 557		0 33, 515, 213	0	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · ·					
90. 00 09000 CLINIC	0. 000000	4, 753		0 740, 787	0	90.00
91.00 09100 EMERGENCY	0. 000000	4, 640, 847		0 11, 313, 446	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000	0		0 1, 426, 786	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		26, 624, 183		0 91, 057, 456	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	CN: 15-0011	Peri od:	Worksheet D	
				From 07/01/2019 To 06/30/2020		narod
				10 00/ 30/ 2020	11/20/2020 1:	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 158129			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. 297587			0 0	1, 926, 210	
57.00 05700 CT SCAN	0. 038583			0 0	300, 372	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 225462			0 0	217, 341	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 361867			0 0		
60. 00 06000 LABORATORY	0. 643038			7 0	1, 344, 812	
60. 01 06001 ONCOLOGY	0. 296381			0 0	797, 456	1
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000			0 0	0	60.02
65. 00 06500 RESPI RATORY THERAPY	0. 461597			0 0	762, 057	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 313909			0 0	30, 176	
69. 00 06900 ELECTROCARDI OLOGY	0. 184564			0 0	461, 506	1
69. 01 06901 CARDI AC REHAB	0. 630942			0 0	275, 028	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 188667	33, 515, 213		0 6, 251	6, 323, 215	73.00
OUTPATIENT SERVICE COST CENTERS	1	1				
90. 00 09000 CLINIC	0. 800041			0 0		90.00
91.00 09100 EMERGENCY	0. 158611			0 0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 450414			0 0	642, 644	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0. 521298			0		95.00
200.00 Subtotal (see instructions)		91, 057, 456		7 6, 251	18, 984, 654	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges				_		
202.00 Net Charges (line 200 - line 201)		91, 057, 456		7 6, 251	18, 984, 654	202.00

Health Fina	ncial Systems	MARION GENER	AL HOSPI TAL		In Lieu	u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 07/01/2019 To 06/30/2020	11/20/2020 1	epared: :17 pm
				XVIII	Hospi tal	PPS	
			sts				
	Cost Center Description	Cost Reimbursed	Cost Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	0	0				50.00
51.00 0510	O RECOVERY ROOM	0	0				51.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 0570	O CT SCAN	0	0				57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	O CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00 0600	0 LABORATORY	5	0				60.00
60.01 0600	1 ONCOLOGY	0	0				60.01
60.02 0600	2 RADIATION ONCOLOGY	0	0				60.02
65.00 0650	0 RESPI RATORY THERAPY	0	0				65.00
66.00 0660	O PHYSI CAL THERAPY	0	0				66.00
69.00 0690	0 ELECTROCARDI OLOGY	0	0				69.00
69.01 0690	1 CARDI AC REHAB	0	0				69.01
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0	1, 179				73.00
OUTP.	ATIENT SERVICE COST CENTERS						
90.00 0900		0	0				90.00
91.00 0910	0 EMERGENCY	0	0				91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	1 OBSERVATION BEDS (DISTINCT PART)	0	0				92.01
	R REIMBURSABLE COST CENTERS						
	O AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	5					200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	5	1, 179				202.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0011	Peri od:	Worksheet D	
		Component		From 07/01/2019		norod.
		component	CCN: 15-T011	To 06/30/2020	Date/Time Pre 11/20/2020 1:	
		Title	XVIII	Subprovider -	PPS	<u> </u>
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 0/4 747	10/ 000 /00	0.01710	0 00 (75	570	
50. 00 05000 OPERATING ROOM	1, 864, 747	106, 928, 633				
51.00 05100 RECOVERY ROOM	0	0	0.00000		-	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1,081,592	29, 162, 784				
57.00 05700 CT SCAN	101, 865	37, 275, 548				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	93, 953					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	295, 136					59.00
60. 00 06000 LABORATORY	844, 415					60.00
60. 01 06001 ONCOLOGY	58, 380	7, 842, 483				60.01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0	0.00000		0	60.02
65. 00 06500 RESPIRATORY THERAPY	288, 139					65.00
66. 00 06600 PHYSI CAL THERAPY	126, 655	10, 687, 784				
69. 00 06900 ELECTROCARDI OLOGY	395, 465	12, 855, 180			1, 363	69.00
69. 01 06901 CARDI AC REHAB	70, 762	857, 220			0	69.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	564, 592	96, 250, 704	0.00586	6 319, 976	1, 877	73.00
OUTPATIENT SERVICE COST CENTERS	240, 222	0.050.0(1	0 10502	5 97	10	90.00
	249, 333					
	850, 540					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	8, 171, 988 0			0	92.00 92.01
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0.00000	0 0	0	92.01
95. 00 09500 AMBULANCE SERVICES				1		95.00
200.00 Total (lines 50 through 199)	6, 885, 574	426, 405, 989		2, 948, 037	38, 877	
	0,000,074	420, 400, 969	I	2, 940, 037	30,077	200.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	Provider CCN: 15-0011		Period: Worksheet D From 07/01/2019 Part IV	
THROUGH COSTS		Component (Component CCN: 15-T011			narod
		component	SCN. 13-1011	To 06/30/2020	11/20/2020 1:	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments 2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	54.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 0NC0L0GY	0	0		0 0	0	60.01
60. 02 06002 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	1					
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
OTHER REI MBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES		~			~	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	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component CCN: 15-T011		From 07/01/2019 Part IV		norod.
		component	JCN: 15-1011	To 06/30/2020	Date/Time Pre 11/20/2020 1:	17 nm
		Title	XVIII	Subprovider -	PPS	<u>17 piii</u>
				IRF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum o		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						1 - 0 - 0 - 0
50. 00 05000 OPERATING ROOM	0	0		0 106, 928, 633		
51.00 05100 RECOVERY ROOM	0	0		0 0	01000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 29, 162, 784		
57.00 05700 CT SCAN	0	0		0 37, 275, 548		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 3, 663, 868		1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 9, 078, 310		
60. 00 06000 LABORATORY	0	0		0 18, 700, 441		
60. 01 06001 ONCOLOGY	0	0		0 7, 842, 483		
60. 02 06002 RADIATION ONCOLOGY	0	0		0 0	01000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 8, 111, 158		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 687, 784		1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 12, 855, 180		
69. 01 06901 CARDI AC REHAB	0	0		0 857, 220		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 96, 250, 704	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS	1	-	r		1	_
90. 00 09000 CLINIC	0	0		0 2, 353, 861		
91.00 09100 EMERGENCY	0	0		0 74, 466, 027		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 8, 171, 988		
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		0 426, 405, 989	1	200.00

Health Financial Systems	MARI ON GENERAL	- HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0011	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T011	From 07/01/2019 To 06/30/2020	Part IV Date/Time Pre	narod
		component	CCN. 15-1011	10 00/30/2020	11/20/2020 1:	17 pm
	PPS					
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	r		1			
50.00 05000 OPERATING ROOM	0. 000000	32, 675		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	34, 133		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	66, 124		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	12, 344		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	4, 504		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	82, 546		0 0	0	60.00
60. 01 06001 0NC0L0GY	0. 000000	1, 349		0 0	0	60.01
60. 02 06002 RADIATION ONCOLOGY	0. 000000	0		0 0	0	60. 02
65. 00 06500 RESPI RATORY THERAPY	0. 000000	68, 129		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 165, 273		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	44, 301		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	319, 976		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	97		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	116, 586		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		2, 948, 037	l	0 0	0	200.00

MPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Pre 11/20/2020 1:	parec
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			14, 563	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs	14, 563 0	2.0
00	do not complete this line.		rivate room aays,	Ū	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	11, 311 0	4. 5.
00	reporting period	oni days) thi ough becenib		0	5.0
00	Total swing-bed SNF type inpatient days (including private ro	om 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	m days) through Decembe	r 31 of the cost	0	7.
00	reporting period	5.		Ũ	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	8.
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	4, 589	9.
	newborn days) (see instructions)				1.0
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.
00	December 31 of the cost reporting period (if calendar year, e		ta naam daya)	0	12
2. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including priva	te room days)	0	12.
8.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.
	Total nursery days (title V or XIX only)	am (exer during swring bed	uays)	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	es through December 31	of the cost	0.00	1 17.
	reporting period	C			
8. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18.
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19.
). 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.
	reporting period				
. 00	Total general inpatient routine service cost (see instruction		ting ported (lind	16, 483, 087	
2. 00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	er 31 of the cost repor	ting period (ine	0	22.
8.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24.
	7 x line 19)	·	51 (0	
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.
. 00	x line 20) Total swing-bed cost (see instructions)			0	26.
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		16, 483, 087	27.
8. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed c	harges)	0	28.
	Private room charges (excluding swing-bed charges)		nur ges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	30.
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	, ,		0.00	
	Private room cost differential adjustment (line 3 x line 35)	- /		0.00	36.
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			-
8.00	Adjusted general inpatient routine service cost per diem (see			1, 131. 85	38.
. 00	Program general inpatient routine service cost (line 9 x line	38)		5, 194, 060	39.
0. 00	Medically necessary private room cost applicable to the Progr	. ,		0	
. 00	Total Program general inpatient routine service cost (line 39	1 + 1 + no = 10		5, 194, 060	1 4 1

	Financial Systems	MARION GENERA		01 45 0044		u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		eriod: rom 07/01/2019 o 06/30/2020	Worksheet D-1 Date/Time Pre 11/20/2020 1:	pared:
			Title	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units	1 704 444		1 171 00	051	1 05 1 (00	
43.00 44.00 45.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T	4, 726, 611	3, 206	1, 474. 30	851	1, 254, 629	43.00 44.00 45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			5, 443, 647	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		11, 892, 336	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	922, 483	50.00
51.00	<pre>III) Pass through costs applicable to Program inp. and IV)</pre>	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	474, 746	51.00
52.00	Total Program excludable cost (sum of lines					1, 397, 229	
53.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-ph	ysician anesth	etist, and	10, 495, 107	53.00
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	ine 53)	0	
58.00	Bonus payment (see instructions)	outing ported	anding 1004	undeted and ear	mounded by the	0.00	
59.00	59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th market basket						
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61.00
62.00							
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37)			70.00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v l	ine 35)			72.00 73.00
74.00	Total Program general inpatient routine serv		•				74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	•			art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:						77.00 78.00
78.00 79.00	Aggregate charges to beneficiaries for excess	,	rovi der recor	ds)			79.00
80.00	Total Program routine service costs for comp	• •			us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I						82.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		5)				83.00 84.00
84.00 85.00	Utilization review - physician compensation		ns)				85.00
86.00	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87.00	Total observation bed days (see instructions)		Line 2			3, 252	1
88.00 89.00	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (see	•				1, 131. 85 3, 680, 776	
						,,.,,,,,,	

Health Financial Systems	MARION GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1		
				From 07/01/2019 To 06/30/2020		pared: 17 pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	2, 433, 266	16, 483, 087	0. 14762	2 3, 680, 776	543, 364	90.00	
91.00 Nursing School cost	0	16, 483, 087	0.00000	0 3, 680, 776	0	91.00	
92.00 Allied health cost	0	16, 483, 087	0. 00000	0 3, 680, 776	0	92.00	
93.00 All other Medical Education	0	16, 483, 087	0.00000	0 3, 680, 776	0	93.00	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011 Component CCN: 15-T011 Title XVIII	Peri od: From 07/01/2019 To 06/30/2020 Subprovi der -	Worksheet D-1 Date/Time Pre 11/20/2020 1: PPS	pare
	Cost Center Description		I RF	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			2,665	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	5,7	rivate room davs	2, 665 0	
00	do not complete this line.	ays). It you have only p	rivate room days,	0	J.
00	Semi-private room days (excluding swing-bed and observation b			2, 665	
00	Total swing-bed SNF type inpatient days (including private reporting period	oom days) through Decemb	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.
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.
00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)	un days) arter becember	ST OF the cost	0	0.
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	2, 062	9.
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII (only (including private	room dave)	0	10.
. 00	through December 31 of the cost reporting period (see instruc		room days)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days) after	0	11.
00	December 31 of the cost reporting period (if calendar year, e		t	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	ix only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva	te room days)	0	13.
	after December 31 of the cost reporting period (if calendar			_	
. 00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17.
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period			0.00	'0.
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of	the cost	0.00	20.
. 00	reporting period	es arter becember 51 01		0.00	20.
. 00	Total general inpatient routine service cost (see instruction			3, 716, 162	21.
. 00	Swing-bed cost applicable to SNF type services through December 172	ber 31 of the cost repor	ting period (line	0	22.
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23.
	x line 18)			Ū	201
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24.
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25.
. 00	x line 20)		g per lou (i i i e o	Ũ	20.
. 00	Total swing-bed cost (see instructions)	<i></i>		0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 716, 162	27.
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)		0	0	
0. 00	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- ille 28)		0.000000	
. 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		ctions)	0.00	34.
. 00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 3, 716, 162	
	27 minus line 36)] "
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			1 204 42	1 20
6.00 9.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		1, 394. 43 2, 875, 315	
. 00	Medically necessary private room cost applicable to the Prog	-		2,073,313	
. 00					

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	MARI ON GENERA		CN: 15-0011	In Lie Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-T011	From 07/01/2019 To 06/30/2020		
			e XVIII	Subprovi der -	11/20/2020 1: PPS	
				I RF		
Cost Center Description	Total Inpatient Cost	Total Inpati ent Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00) 42.
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni		(0.0	0 0		<u> </u>
B. 00 INTENSIVE CARE UNIT	0	(0.0	0 0	C	
1. OO CORONARY CARE UNIT 5. OO BURN INTENSIVE CARE UNIT						44.
0. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
7.00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	-
8.00 Program inpatient ancillary service cost			``````````````````````````````````````		874, 031	
.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(see instructi	ons)		3, 749, 346	5 49
0.00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	406, 090	50.
III)	nnationt andillar	u convioco (f	From What D	our of Dorto II	20.077	7 51
.00 Pass through costs applicable to Program i and IV)	npatrent and riar	y services (i	TOM WKSL. D,	Sum of Parts II	38, 877	51
2.00 Total Program excludable cost (sum of line					444, 967	
3.00 Total Program inpatient operating cost exe medical education costs (line 49 minus lin		lated, non-ph	iysi ci an anest	hetist, and	3, 304, 379	9 53
TARGET AMOUNT AND LIMIT COMPUTATION	10 52)					
0 Program di scharges					0	
.00 Target amount per discharge .00 Target amount (line 54 x line 55)					0.00	
.00 Difference between adjusted inpatient oper	rating cost and ta	rget amount (line 56 minus	line 53)	0	
 .00 Bonus payment (see instructions) .00 Lesser of lines 53/54 or 55 from the cost 	reporting period	ending 1006	undated and c	ompounded by the	0.00	
market basket	reporting period	enuring 1990,	upuateu anu c	ompounded by the	0.00	57
0.00 Lesser of lines 53/54 or 55 from prior yea					0.00	
1.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less t					C) 61
amount (line 56), otherwise enter zero (se						
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive pa	avment (see instru	ctions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						1 03
. 00 Medicare swing-bed SNF inpatient routine of	costs through Dece	mber 31 of th	e cost report	ing period (See	0	64
instructions)(title XVIII only) 5.00 Medicare swing-bed SNF inpatient routine of	costs after Decemb	er 31 of the	cost reportin	g period (See	c c	65
instructions)(title XVIII only)			·			
 D. 00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions) 	utine costs (line	64 plus line	65)(title XVI	II only). For	0	66
7.00 Title V or XIX swing-bed NF inpatient rout	tine costs through	December 31	of the cost r	eporting period	0	67
(line 12 x line 19)	ting goots often D	acamban 21 of	the east rea	arting pariod		
3.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	line costs arter D	ecemper 31 OI	the cost rep	orting period	C	68
P. 00 Total title V or XIX swing-bed NF inpatier					0	69
PART III - SKILLED NURSING FACILITY, OTHER 0.00 Skilled nursing facility/other nursing fac)		70
. 00 Adjusted general inpatient routine service				,		71
.00 Program routine service cost (line 9 x lin	,	(lipo 14 v l	ino 25)			72
00 Medically necessary private room cost appl 00 Total Program general inpatient routine se	Ũ	•	,			73
6.00 Capital-related cost allocated to inpatier				Part II, column		75
26, line 45) .00 Per diem capital-related costs (line 75 ÷	line 2)					76
.00 Program capital-related costs (line 9 x li						77
.00 Inpatient routine service cost (line 74 mi	,	rovidor roc	de)			78
.00 Aggregate charges to beneficiaries for exo .00 Total Program routine service costs for co				nus line 79)		80
.00 Inpatient routine service cost per diem li	mitation			/		81
 00 Inpatient routine service cost limitation 00 Reasonable inpatient routine service costs 	•					82
. 00 Program inpatient ancillary services (see	•	<i></i>				84
5.00 Utilization review - physician compensation	on (see instructio					85
D. 00 Total Program inpatient operating costs (S PART IV - COMPUTATION OF OBSERVATION BED F		rough 85)				86
7.00 Total observation bed days (see instruction					C	87.
3.00 Adjusted general inpatient routine cost pe		line 2)			0.00	
9.00 Observation bed cost (line 87 x line 88) ((see instructions)				1 0	89

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2019	Worksheet D-1	
C			Component CCN: 15-T011		Date/Time Pre 11/20/2020 1:	
	Title	XVIII	Subprovider -	PPS		
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	524, 857	3, 716, 162	0. 14123	36 0	0	90.00
91.00 Nursing School cost	0	3, 716, 162	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 716, 162	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 716, 162	0. 00000	0 0	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period: From 07/01/2019	Worksheet D-1	
			To 06/30/2020	Date/Time Pre 11/20/2020 1:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		14, 563	1 1
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days,	14, 563 0	4
	do not complete this line.				
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	11, 311 0	Į
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	0
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	-
00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	577	ç
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days) after	0	1.
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te 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			0	1:
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr Total necessary days (it is a very select)				1
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 616 0	
00	SWING BED ADJUSTMENT	and the such December 21	-6 the east	0.00	1 .
	Medicare rate for swing-bed SNF services applicable to servic reporting period	5		0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	U U		0.00	
	Medicaid rate for swing-bed NF services applicable to service reporting period		the cost	0.00	
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	16, 483, 087 0	2
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line 6	0	2
1.00	x line 18) Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	2
	x line 20) Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			16, 483, 087	
	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	
	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)			0.00	
	Average per diem private room charge differential (line 32 mi	, (ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 16, 483, 087	30
- 0	27 minus line 36)			,,,,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 131. 85	38
3.00					
9.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	e 38)		653, 077 0	

	Financial Systems	MARI ON GENERA		ON 15 0011		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		eriod: rom 07/01/2019 o 06/30/2020		pared:
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col . 2) 3.00	4.00	<u>col.4)</u> 5.00	
42.00	NURSERY (title V & XIX only)	1, 921, 773					42.00
	Intensive Care Type Inpatient Hospital Units	· · ·		1			
43.00	INTENSIVE CARE UNIT	4, 726, 611	3, 206	1, 474. 30	0	0	
44.00 45.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00 45.00
45.00	SURGI CAL I NTENSI VE CARE UNI T						45.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st D_3 col (3 Line 200)			1.00 421,281	48.00
49.00	Total Program inpatient costs (sum of lines		· · ·	ons)		1, 074, 358	
	PASS THROUGH COST ADJUSTMENTS	v ,					
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51.00	III) Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst D si	um of Parts II	0	51.00
51.00	and IV)						01.00
52.00	Total Program excludable cost (sum of lines					0	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)				L	
	Program di scharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)				50)	0	56.00
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (line 56 minus i	ine 53)	0	57.00 58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	portina period	endi na 1996.	updated and cor	npounded by the	-	
	market basket	01	0		1		
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61.00	If line 53/54 is less than the lower of line: which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see				the turget		
62.00							
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reportin	ng period (See	0	64.00
	instructions)(title XVIII only)	-					
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII)	only) For	0	66.00
	CAH (see instructions)		p				
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	h December 31	of the cost rep	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after l	December 31 of	the cost repo	ting period	0	68.00
00.00	(line 13 x line 20)				ting period		00.00
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of	2		• •			71.00
72.00	Program routine service cost (line 9 x line			,			72.00
73.00	Medically necessary private room cost application	U U	•				73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II column		74.00 75.00
70.00	26, line 45)						/0.00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77.00	Program capital -related costs (line 9 x line	· ·					77.00
78.00 79.00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		provi der i recor	ds)			78.00 79.00
80.00	Total Program routine service costs for compa	· · ·		,	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I		· · ·				82.00 83.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		15)				83.00
85.00	Utilization review - physician compensation		ons)				85.00
86.00	Total Program inpatient operating costs (sum	of lines 83 th				L	86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					3, 252	87.00
87.00 88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷line 2)			3, 252 1, 131. 85	
	Observation bed cost (line 87 x line 88) (see	•				3, 680, 776	

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020		pared: 17 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 433, 266	16, 483, 087	0. 14762	2 3, 680, 776	543, 364	90.00
91.00 Nursing School cost	0	16, 483, 087	0.00000	0 3, 680, 776	0	91.00
92.00 Allied health cost	0	16, 483, 087	0. 00000	0 3, 680, 776	0	92.00
93.00 All other Medical Education	0	16, 483, 087	0.00000	0 3, 680, 776	0	93.00

UMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Peri od:	Worksheet D-1	2552
		Component CCN: 15-T011	From 07/01/2019 To 06/30/2020	Date/Time Pre 11/20/2020 1:	
		Title XIX	Subprovider -	Cost	<u>17 p</u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			2,665	1
00	Inpatient days (including private room days, excluding swing			2,665	2
00	Private room days (excluding swing-bed and observation bed do do not complete this line.	ays). It you nave only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation)	bed days)		2, 665	4
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	0	5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	am dava) through Decembe	r 21 of the east	0	₋
00	Total swing-bed NF type inpatient days (including private row reporting period	oni days) thi ough becenbe	I SI UI LINE CUSL	0	7
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	11	9
	newborn days) (see instructions)			0	10
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,	5 . 5 .		-	
2.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12
	through December 31 of the cost reporting period				
8.00	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 Prog			0	14
5.00	Total nursery days (title V or XIX only)	Tam (exer daring swring bed	uuys)	1, 616	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17
3. 00	reporting period	cos after December 21 of	the cost	0.00	18
5. 00	Medicare rate for swing-bed SNF services applicable to servi- reporting period	ces al tel December 31 01	the cost	0.00	10
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period	Ū.			
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
1 00	reporting period	72)		2 714 142	21
1.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ting period (line	3, 716, 162 0	
2.00	5 x line 17)	bel 31 01 the cost repor	ting period (inte	0	22
3.00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
1.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24
- 00	7 x line 19) Swing had cost applicable to NE type corvices ofter December	21 of the cost reportin	a pariod (line 9	0	25
5.00	Swing-bed cost applicable to NF type services after December x line 20)	SI OI THE COST LEPOLTIN	g period (inne o	0	20
5.00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 716, 162	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	
0. 00 0. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
. 00	Average per diem private room charge differential (line 32 m		ctions)	0.00	
. 00	Average per diem private room cost differential (line 34×1	ine 31)		0.00	
0.00	Private room cost differential adjustment (line 3 x line 35)	and private reem cost d	ifforantial (line	0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	inerential (IINe	3, 716, 162	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (se	e instructions)		1, 394. 43	
	Program general inpatient routine service cost (line 9 x lin			15, 339	
	Medically necessary private room cost applicable to the Prog			0	
	Total Program general inpatient routine service cost (line 3'	9 + IINE 40)		15, 339	41

alth Financial Systems DMPUTATION OF INPATIENT OPERATING COST	MARI ON GENERA		CN: 15-0011	In Lie Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-T011	From 07/01/2019 To 06/30/2020	Date/Time Pre	epare
			e XIX	Subprovider -	11/20/2020 1: Cost	:17 p
				I RF		
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	12
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Un	0 ts	(0.0	0 0	C) 42.
3. 00 I NTENSI VE CARE UNI T	0	(0.0	0 0	C	
4. 00 CORONARY CARE UNIT						44.
5. OO BURN INTENSIVE CARE UNIT 5. OO SURGICAL INTENSIVE CARE UNIT						45.
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
00 Program inpatient ancillary service cost	(Wkst. D-3. col. 3	. Line 200)			1.00 12,737	/ 48
.00 Total Program inpatient costs (sum of lin			ons)		28, 076	
PASS THROUGH COST ADJUSTMENTS		(£	www.et D ev	f Danta I		
00 Pass through costs applicable to Program	inpatient routine	services (ind	m wkst. D, su	m or parts I and) C	50
.00 Pass through costs applicable to Program	inpatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	C	51
and IV)	as EQ and E1)					1 50
2.00 Total Program excludable cost (sum of lin 3.00 Total Program inpatient operating cost ex		lated, non-ph	vsician anest	hetist. and		
medical education costs (line 49 minus li						
TARGET AMOUNT AND LIMIT COMPUTATION					l c	54
.00 Program discharges .00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					C	
. 00 Difference between adjusted inpatient ope	rating cost and ta	rget amount (line 56 minus	line 53)	C	
8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost	reporting period	endina 1996	undated and c	ompounded by the	0. OC	
market basket	reporting period	churng 1770,	apaarea ana e	ompounded by the	0.00	
0.00 Lesser of lines 53/54 or 55 from prior ye					0.00	
1.00 If line 53/54 is less than the lower of l which operating costs (line 53) are less					C) 61
amount (line 56), otherwise enter zero (s		3 (11103 34 7	00), 01 1% 0	i the target		
2.00 Relief payment (see instructions)					C	
3. 00 Allowable Inpatient cost plus incentive p PROGRAM INPATIENT ROUTINE SWING BED COST	ayment (see Instru	ctions)			C) 63
4.00 Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of th	e cost report	ing period (See	C	64
instructions)(title XVIII only)	anata aftar Daaamh	or 21 of the	agat rapartin	a partial (Caa		
5.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decemb	er 31 of the	cost reportin	g period (See	C) 65.
.00 Total Medicare swing-bed SNF inpatient ro	utine costs (line	64 plus line	65)(title XVI	II only). For	C	66
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient rou	tipo costs through	Decombor 21	of the cost r	oporting pariod		67
(line 12 x line 19)	time costs through	December 31	of the cost i	eporting period		
3.00 Title V or XIX swing-bed NF inpatient rou	tine costs after D	ecember 31 of	the cost rep	orting period	C	68
lline 13 x line 20) 2.00 Total title V or XIX swing-bed NF inpatie	nt routino costs (lino 67 Lin	o 69)		C	69
PART III - SKILLED NURSING FACILITY, OTHE						1 07
0.00 Skilled nursing facility/other nursing fa)		70
.00 Adjusted general inpatient routine servic .00 Program routine service cost (line 9 x li		ine 70 ÷ line	2)			71
. 00 Medically necessary private room cost app		(line 14 x l	ine 35)			73
.00 Total Program general inpatient routine s						74
Constant of the second sec	nt routine service	costs (from	Worksheet B,	Part II, column		75
. 00 Per diem capital-related costs (line 75 ÷	line 2)					76
.00 Program capital-related costs (line 9 x l	ine 76)					77
.00 Inpatient routine service cost (line 74 m .00 Aggregate charges to beneficiaries for ex	,	rovi der rocor	ds)			78
.00 Total Program routine service costs for c				nus line 79)		80
.00 Inpatient routine service cost per diem I	imitation		,	,		81
. 00 Inpatient routine service cost limitation	•					82
 00 Reasonable inpatient routine service cost 00 Program inpatient ancillary services (see 	•	5)				83
5.00 Utilization review - physician compensati		ns)				85
0.00 Total Program inpatient operating costs (rough 85)				86.
7.00 Total observation bed days (see instructi					C	87.
8.00 Adjusted general inpatient routine cost p	,	line 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)						89

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2019	Worksheet D-1	
		Component (CCN: 15-T011	To 06/30/2020		pared: 17 pm
		Ti tl	e XIX	Subprovider -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				. 89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	524, 857	3, 716, 162	0. 14123	36 0	0	90.00
91.00 Nursing School cost	0	3, 716, 162	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 716, 162	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 716, 162	0.0000	00 0	0	93.00

Health Financial Systems MARION GENER		011 15 0011		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Period: From 07/01/2019	Worksheet D-3	5
			To 06/30/2020		nared.
			10 00/00/2020	11/20/2020 1:	17 pm
	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	
INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
30. 00 03000 ADULTS & PEDIATRICS			5, 736, 888		30.0
31.00 03100 I NTENSI VE CARE UNI T			1, 844, 968		31.0
40. 00 04000 SUBPROVI DER - I PF			0		40.0
41.00 04100 SUBPROVIDER - IRF			0		41.0
42. 00 04200 SUBPROVI DER			0		42.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS		0.4504	00 10 001 100	4 (05 740	1 50 0
50. 00 05000 OPERATING ROOM		0. 1581			
51.00 O5100 RECOVERY ROOM		0.0000		-	51.0
54.00 O5400 RADI OLOGY-DI AGNOSTI C		0. 2975			
57.00 05700 CT SCAN		0.0385			
58.00 O5800 MAGNETIC RESONANCE I MAGI NG (MRI)		0. 2254			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.3618			
50. 00 06000 LABORATORY		0.6430			
60. 01 06001 0NC0L0GY		0. 2963			
50. 02 06002 RADI ATI ON ONCOLOGY		0.0000		, v	
		0.4615			
66. 00 06600 PHYSI CAL THERAPY 59. 00 06900 ELECTROCARDI OLOGY		0.3139			
		0. 1845 0. 6309			
69. 01 06901 CARDI AC REHAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 8309		-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	72.0
72. 00 07200 TMPL. DEV. CHARGED TO PATTENTS 73. 00 07300 DRUGS CHARGED TO PATTENTS		0.0000		-	
OUTPATIENT SERVICE COST CENTERS		0. 1000	2,477,557	407,433	/3.0
90. 00 09000 CLINIC		0, 8000	41 4, 753	3, 803	90.0
90.00 09100 EMERGENCY		0. 8000			
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1586			
92. 01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.4504		-	
OTHER REIMBURSABLE COST CENTERS		0.0000	001 0	0	1 72.0
95. 00 09500 AMBULANCE SERVICES		1			95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			26, 624, 183	5, 443, 647	
200.00 Less PBP Clinic Laboratory Services-Program only cha			20, 024, 103		200.0
202.00 Net charges (line 200 minus line 201)	iges (inte of)		26, 624, 183		201.0
202.00 Inter charges (The 200 minus the 201)		1	20, 024, 103	1	202.0

Health Financial Systems MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Period:	Worksheet D-3	3
	Component	CCN: 15-T011	From 07/01/2019 To 06/30/2020	Date/Time Pre 11/20/2020 1:	epared: 17 pm
	Title	e XVIII	Subprovider -	PPS	
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30,00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			2, 707, 407		41.00
42. 00 04200 SUBPROVI DER			2,707,107		42.00
43. 00 04300 NURSERY			-		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1581	29 32, 675	5, 167	50.00
51.00 05100 RECOVERY ROOM		0.0000	0 00	C	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2975	37 34, 133	10, 158	54.00
57. 00 05700 CT SCAN		0. 0385	66, 124	2, 551	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2254	52 12, 344	2, 783	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.3618	67 4, 504	1,630	59.00
60. 00 06000 LABORATORY		0.6430	38 82, 546	53,080	60.00
60. 01 06001 ONCOLOGY		0. 2963	31 1, 349	400	60.01
60. 02 06002 RADIATION ONCOLOGY		0.0000		C	60.02
65. 00 06500 RESPI RATORY THERAPY		0. 4615		31, 448	
66. 00 06600 PHYSI CAL THERAPY		0. 3139		679, 699	
69. 00 06900 ELECTROCARDI OLOGY		0. 1845		8, 176	
69. 01 06901 CARDI AC REHAB		0. 6309		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. 1886	67 319, 976	60, 369	73.00
OUTPATI ENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.8000		78	
91.00 09100 EMERGENCY		0. 1586		18, 492	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 4504			
92.01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0.0000	0	(92.01
95. 00 09500 AMBULANCE SERVICES		1			05 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 948, 037	874, 031	95.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	nes (line 61)		2, 940, 037	074, 031	200.00
202.00 Net charges (line 200 minus line 201)			2, 948, 037		201.00
202.00 met charges (The 200 minus The 201)		1	2, 740, 037		202.00

Health Financial Systems MARION GENER		01 45 0014		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Period: From 07/01/2019	Worksheet D-3	3
			To 06/30/2020		nared
			10 00/ 30/ 2020	11/20/2020 1:	17 pm
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	st Inpatient	Inpatient	
•		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			5	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			836, 543		30.0
31.00 03100 INTENSIVE CARE UNIT			166, 608		31.0
40. 00 04000 SUBPROVIDER - IPF			0		40.0
41.00 04100 SUBPROVIDER - IRF			0		41.0
42. 00 04200 SUBPROVI DER			0		42.0
43. 00 04300 NURSERY			0		43.0
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 1581	29 690, 873	109, 247	50.0
51.00 05100 RECOVERY ROOM		0.0000	00 0	0	51.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2975	87 75, 302	22, 409	54.0
57.00 05700 CT SCAN		0. 0385	83 163, 586	6, 312	57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2254	62 7, 597	1, 713	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.3618	67 131, 997	47, 765	59.0
60. 00 06000 LABORATORY		0. 6430	38 138, 060	88, 778	60.0
60. 01 06001 ONCOLOGY		0. 2963	81 0	0	60.0
60. 02 06002 RADIATION ONCOLOGY		0.0000	00 0	l o	60.0
65. 00 06500 RESPI RATORY THERAPY		0. 4615	97 50,009	23, 084	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 3139			
69. 00 06900 ELECTROCARDI OLOGY		0. 1845			
59. 01 06901 CARDI AC REHAB		0. 6309			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1886		-	
OUTPATIENT SERVICE COST CENTERS		0.1000	07 175,100		1 / 5. 0
90. 00 09000 CLINIC		0, 8000	41 0	0	90.0
91.00 09100 EMERGENCY		0. 1586		65, 794	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4504			
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4304		-	
OTHER REIMBURSABLE COST CENTERS		0.0000	00 0	0	72.0
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 960, 555	421, 281	
201.00 Less PBP Clinic Laboratory Services-Program only char	caes (line 61)		1, 900, 555		201.0
202.00 Net charges (line 200 minus line 201)	ges (The OI)		1, 960, 555		201.0
202.00 Incr charges (The 200 minus The 201)		I	1, 700, 555	I	1202.0

Health Financial Systems MARION GENERAL				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T011	From 07/01/2019 To 06/30/2020	Date/Time Pre	nared
	component	CCN. 13-1011	10 00/ 30/ 2020	11/20/2020 1:	
	Ti tl	e XIX	Subprovider -	Cost	
		_	I RF		-
Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-		
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41.00 04100 SUBPROVIDER - IRF			31, 927		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATING ROOM		0. 1581		0	
51. 00 05100 RECOVERY ROOM		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2975			1
57. 00 05700 CT SCAN		0.0385		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2254		0	
59. 00 05900 CARDIAC CATHETERIZATION		0.3618		0	
60. 00 06000 LABORATORY		0.6430		1, 360	
60. 01 06001 0NC0L0GY		0. 2963		0	
60. 02 06002 RADI ATI ON ONCOLOGY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.4615		101	1
66. 00 06600 PHYSI CAL THERAPY		0. 3139		7, 218	1
69. 00 06900 ELECTROCARDI OLOGY		0. 1845		0	
69. 01 06901 CARDI AC REHAB		0.6309		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		0.0000		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1886	67 17,046	3, 216	73.00
		0.0000	41		00.00
90. 00 09000 CLINIC		0.8000		0	
91.00 09100 EMERGENCY		0. 1586		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.4504		0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS					05 00
95.00 09500 AMBULANCE SERVICES			45 004	10 707	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	a (line (1)		45, 204	12, 737	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line ol)		45 204		201.00
202.00 Net charges (line 200 minus line 201)		1	45, 204		202.00

CALCULAT	TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Peri od:	Worksheet E	
			From 07/01/2019		
			To 06/30/2020		
		Title XVIII	Hospi tal	PPS	<u> </u>
				1.00	
PÆ	ART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.01 DI	NRG Amounts Other than Outlier Payments NRG amounts other than outlier payments for discharges occurn	ring prior to October 1	(see	0 2, 993, 580	
1.02 DI	nstructions) NG amounts other than outlier payments for discharges occur nstructions)	ring on or after October	1 (see	8, 319, 055	1. 02
1.03 DI	IRG for federal specific operating payment for Model 4 BPCI 1 (see instructions)	for di scharges occurri ng	prior to October	0	1.03
1.04 DI	NG for federal specific operating payment for Model 4 BPCI 1 Detober 1 (see instructions)	for di scharges occurri ng	on or after	0	1.04
2.00 0	utlier payments for discharges. (see instructions) Dutlier reconciliation amount			0	2.00 2.01
1	Dutlier payment for discharges for Model 4 BPCI (see instruc	tions)		0	
	Outlier payments for discharges occurring prior to October 1			57, 128	
	Outlier payments for discharges occurring on or after October	r 1 (see instructions)		36, 882	
	lanaged Care Simulated Payments Wed days available divided by number of days in the cost repo	orting poriod (soo instr	uctions)	0 103.68	
	ndirect Medical Education Adjustment	or tring period (see this ti		103.08	4.00
5.00 F	TE count for allopathic and osteopathic programs for the most pr before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.00
6.00 F	TE count for allopathic and osteopathic programs that meet new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap for	0.00	6.00
7.01 A	MA Section 422 reduction amount to the LME cap as specified CA § 5503 reduction amount to the LME cap as specified under			0.00 0.00	
8.00 Ad	ost report straddles July 1, 2011 then see instructions. djustment (increase or decrease) to the FTE count for allopa			0.00	8.00
10	ffiliated programs in accordance with 42 CFR 413.75(b), 413. 998), and 67 FR 50069 (August 1, 2002).				
re	he amount of increase if the hospital was awarded FTE cap sleeport straddles July 1, 2011, see instructions.				
u	he amount of increase if the hospital was awarded FTE cap slinder § 5506 of ACA. (see instructions)		0	0.00	
ii	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin nstructions)			0.00	
	TE count for allopathic and osteopathic programs in the curr TE count for residents in dental and podiatric programs.	rent year from your reco	ras	0.00 0.00	
	Current year allowable FTE (see instructions)			0.00	12.00
	otal allowable FTE count for the prior year.			0.00	1
0	otal allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,	0.00	
	Sum of lines 12 through 14 divided by 3.				15.00
	djustment for residents in initial years of the program djustment for residents displaced by program or hospital clo	OSUFA			16.00 17.00
	djusted rolling average FTE count	usule			18.00
	Current year resident to bed ratio (line 18 divided by line 4	4).		0. 000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
	inter the lesser of lines 19 or 20 (see instructions)			0.00000	
1	ME payment adjustment (see instructions)			0	
١r	ME payment adjustment - Managed Care (see instructions) ndirect Medical Education Adjustment for the Add-on for § 42 wrbar of additional planathic and estamathic MC FT reci		CED 412 105	0	
(1	lumber of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).	uent cap slots under 42	UFK 412.105	0.00	
25.00 I t	ME FTE Resident Count Over Cap (see instructions) f the amount on line 24 is greater than -O-, then enter the pstructions)	lower of line 23 or lin	e 24 (see	0.00 0.00	
	nstructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
	ME payments adjustment factor. (see instructions)			0.000000	
	ME add-on adjustment amount (see instructions)			0	
	ME add-on adjustment amount - Managed Care (see instructions	s)		0	
29.01 To	otal IME payment (sum of lines 22 and 28) otal IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		0	
	isproportionate Share Adjustment	pationt days (ass instant	ati anc)	E (0	20.00
	Percentage of SSI recipient patient days to Medicare Part A p Percentage of Medicaid patient days (see instructions)	patient days (see instru	ctions)	5.62 27.55	
	Sum of lines 30 and 31			27.55	
	Ilowable disproportionate share percentage (see instructions	s)		16. 57	
33.00 AI					34.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020	Date/Time Pre	
		Title XVIII	Hospi tal	11/20/2020 1: PPS	17 6
				0n/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		8, 272, 872, 447	8, 350, 599, 096	35
5. 01	Factor 3 (see instructions)		0.000277059	0.000307154	35
5. 02	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (s	see 2, 292, 074	2, 564, 920	35
	instructions)	,			
. 03	Pro rata share of the hospital uncompensated care payment am	nount (see instructions)	577, 729	1, 920, 186	35
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.	03)	2, 497, 915		36
	Additional payment for high percentage of ESRD beneficiary d				
. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40
	652, 682, 683, 684 and 685 (see instructions)			0 (10) 1 (1	
			Before 1/1	0n/After 1/1	
00	Tatal ECDD Madi aana di cabangaa aval udi ng MC DDCa (E2 (02	(02 (04 on (05 (coo	1.00	1.01	41
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	083, 084 all 085. (See	0	0	41
. 01	Total ESRD Medicare covered and paid discharges excluding MS	-DPCs 652 682 683 68	34 0	0	41
. 01	an 685. (see instructions)	-0103 032, 002, 003, 00	0	0	41
. 00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43
	instructions)				
. 00	Ratio of average length of stay to one week (line 43 divided	lby line 41 divided by 7	0. 000000		44
	days)				
. 00	Average weekly cost for dialysis treatments (see instruction	<i>·</i>	0.00	0.00	
. 00	Total additional payment (line 45 times line 44 times line 4	1.01)	0		46
. 00	Subtotal (see instructions)		14, 373, 186		47
. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	12, 318, 865		48
	only. (see instructions)			Amount	
				Amount 1.00	
. 00	Total payment for inpatient operating costs (see instruction	ns)		14, 373, 186	49
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a		.)	927, 543	50
. 00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51
. 00	Direct graduate medical education payment (from Wkst. E-4, I			0	52
. 00	Nursing and Allied Health Managed Care payment			0	53
. 00	Special add-on payments for new technologies			0	54
. 01	Islet isolation add-on payment			0	54
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55
. 00	Cost of physicians' services in a teaching hospital (see int			0	56
. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57
	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58
	Total (sum of amounts on lines 49 through 58)			15, 300, 729	59 60
. 00	Primary payer payments			6, 606	
. 00 . 00	Total amount navable for program bonoficiarios (line 50 minu	is line 60)		15 20/ 122	
. 00 . 00 . 00	Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	ıs line 60)		15, 294, 123	6
. 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries	ıs line 60)		1, 556, 632	61 62
. 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	us line 60)		1, 556, 632 21, 791	61 62 63
. 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	us line 60)		1, 556, 632 21, 791 154, 461	61 62 63 64
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			1, 556, 632 21, 791 154, 461 100, 400	61 62 63 64 65
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins			1, 556, 632 21, 791 154, 461	61 62 63 64 65 66
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	tructions)	see instructions)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100	61 62 63 64 65 66 67
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	structions) • applicable to MS-DRGs (. ,	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100	61 62 63 64 65 66 67 68
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	structions) • applicable to MS-DRGs (. ,	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0	61 62 63 64 65 67 68 69
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	structions) applicable to MS-DRGs (.(For SCH see instructio	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0	61 62 63 64 65 67 68 69 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) BILLING CORRECTION Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	tructions) applicable to MS-DRGs (.(For SCH see instruction tration) adjustment (see	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0 18, 025	61 62 63 64 65 67 68 69 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) BILLING CORRECTION Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	tructions) applicable to MS-DRGs (.(For SCH see instruction) adjustment (see	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0 18, 025 0	61 62 63 64 65 66 67 68 69 70 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) BILLING CORRECTION Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	tructions) applicable to MS-DRGs (.(For SCH see instruction) adjustment (see	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0 18, 025 0 0 0 0 0	61 62 63 64 65 66 67 68 69 70 70 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) BILLING CORRECTION Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	tructions) applicable to MS-DRGs (.(For SCH see instruction) adjustment (see	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0 18, 025 0 0 0 0 0 0 0 0	61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) BILLING CORRECTION Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	tructions) applicable to MS-DRGs (.(For SCH see instruction) adjustment (see	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0 18, 025 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61 62 63 64 65 66 67 70 70 70 70 70 70 70 70 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) BILLING CORRECTION Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	tructions) applicable to MS-DRGs (.(For SCH see instruction) adjustment (see	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0 18, 025 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61 62 63 64 65 66 67 70 70 70 70 70 70 70 70 70 70 70 70 70
	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) BILLING CORRECTION Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	tructions) applicable to MS-DRGs (.(For SCH see instruction) adjustment (see	ons)	1, 556, 632 21, 791 154, 461 100, 400 27, 241 13, 816, 100 0 18, 025 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61 62 63 64 65 66 67 70 70 70 70 70 70 70 70 70 70 70 70 70

ALUULI	ATION OF REIMBURSEMENT SETTLEMENT	HOSPI TAL Provi der C	CN: 15-0011	Peri od:	u of Form CMS-2 Worksheet E	
				From 07/01/2019 To 06/30/2020	Part A Date/Time Pre	pare
		Title	XVIII	Hospi tal	11/20/2020 1: PPS	17 pi
		II ti c		(yyyy)	Amount	
				0	1.00	
D. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column O		0	0	70.
). 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70.
). 98	Low Volume Payment-3				0	70.
). 99	HAC adjustment amount (see instructions)				153, 449	70.
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			13, 724, 924	
	Sequestration adjustment (see instructions)				229, 206	
	Demonstration payment adjustment amount after sequestration				0	
1.03	Sequestration adjustment-PARHM pass-throughs				12 00/ 010	71.
2.00 2.01	Interim payments				13, 096, 819	72.
3.00	Interim payments-PARHM Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)				0	73.
	Balance due provider/program (line 71 minus lines 71.01, 71.0)2 72 and			398, 899	
	73)	2, 12, and			0,0,0,7	
4. 01	Balance due provider/program-PARHM (see instructions)					74.
5.00	Protested amounts (nonallowable cost report items) in accorda	ance with			241, 941	75
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90
	plus 2.04 (see instructions)					
. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	
-	Operating outlier reconciliation adjustment amount (see instr				0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
. 00						
	The rate used to calculate the time value of money (see instr				0.00	
5.00	Time value of money for operating expenses (see instructions)				0	95.
5.00	3,1			Prior to 10/1	0 0	95.
5. 00 5. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc			Pri or to 10/1 1.00	0 0	95.
. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount			1.00	0 0 0n/After 10/1 2.00	95. 96.
. 00 . 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions)				0 0 0n/After 10/1 2.00	95
. 00 . 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	0 0 0n/After 10/1 2.00 0	95 96 100
. 00 . 00 0. 00 1. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	ctions)		0.000000000	0 0 0n/After 10/1 2.00 0 0.000000000	95 96 100 101
. 00 . 00 0. 00 1. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ctions)		1.00	0 0 0n/After 10/1 2.00 0 0.000000000	95 96 100 101
. 00 . 00 0. 00 1. 00 2. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	ctions)		0.000000000	0 0 0n/After 10/1 2.00 0 0.000000000	95 96 100 101 102
. 00 . 00 0. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		1.00 0 0.000000000 0	0 0n/After 10/1 2.00 0.000000000 0 0.000000000 0	95 96 100 101 102 103
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	ns) ns) rration) Adju		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0.000000000 0 0.000000000 0	95 96 100 101 102 103
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment f	ns) ns) rration) Adju		1.00 0 0.000000000 0 0.0000	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0.0000 0	95 96 100 101 102 103 104
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment HRR adjustment amount for HSP bonus payment Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	ns) ns) rration) Adju		1.00 0 0.000000000 0 0.0000	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0.0000 0	95 96 100 101 102 103 104
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ns) s) eriod under		1.00 0 0.000000000 0 0.0000	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	95 96 100 101 102 103 104 200
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instructions) HVBP adjustment factor (see instructions) HVRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	ns) s) eriod under		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0.000000000 0 0.0000 0 0	95 96 100 101 102 103 104 200
00 00 00 00 00 00 00 00 00 00 00 00 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions)	ns) s) eriod under		1.00 0 0.000000000 0 0.0000	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0	95 96 100 101 102 103 104 200 201 202
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare di scharges (see instructions) Case-mix adjustment factor (see instructions)	ns) (is) (is) (internation) Adju (internation) Adju	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0.0000	95 96 100 101 102 103 104 200 201 202
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ns) (is) (is) (internation) Adju (internation) Adju	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0.0000	95 96 100 101 102 103 104 200 201 202
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ns) (is) (is) (internation) Adju (internation) Adju	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0	95 96 100 101 102 103 104 200 201 202 203
00 00 00 00 00 00 00 00 00 00 00 00 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ns) (is) (is) (internation) Adju (internation) Adju	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0	95 96 100 101 102 103 104 200 201 202 203 204
00 00 00 00 00 00 00 00 00 00 00 00 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare di scharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ns) (ctions) (ns) (crion) Adj (crion) Adj	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000	95 96 100 101 102 103 104 200 201 202 203 204 204 205
. 00 . 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR adjustment factor (see instructions) Computing Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare di scharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ns) (ctions) (ns) (crion) Adj (crion) Adj	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000	95 96 100 101 102 103 104 200 201 202 203 204 204 205
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	ns) rration) Adju rration) Adju rriod under ne 49) n first year rructions)	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0	95 96 100 101 102 103 104 200 201 202 203 204 205 206 207
00 00 00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 5.00 5.00 7.00 3.00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ns) rration) Adju rration) Adju rriod under ne 49) n first year rructions)	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0 0	95 96 100 101 102 103 104 200 201 202 203 204 205 206 207 208
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ns) rration) Adju rration) Adju rriod under ne 49) n first year rructions)	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 000000000000000000000000000000000000	95 96 100 101 102 103 104 200 201 200 203 204 205 206 206 207 208 209
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ns) rration) Adji rration) Adji rriod under ne 49) n first year rructions) line 59)	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0	95 96 100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ns) rration) Adji rration) Adji rriod under ne 49) n first year rructions) line 59)	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0	95 96 100 101 102
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ns) rations) ration) Adju ration) Adju ration under heriod under h	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 000000000000000000000000000000000000	95 96 100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (see instructions)	ns) rations) ration) Adju ration) Adju ration under heriod under h	the 21st	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0 0	95 96 100 101 102 103 104 200 201 202 203 203 204 205 206 207 208 209 210 211
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ns) rration) Adji rration) Adji rriod under ne 49) n first year rructions) line 59) 211)	of the curre	1.00 0.000000000 0.000000000 0.0000 0	0 0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0	95 96 100 101 102 103 104 200 201 203 203 203 204 205 206 207 208 209 210 211

	Financial Systems		MARI ON GENERA	Provider C		Peri od: From 07/01/2019 To 06/30/2020		t 4 pare
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	XVIII Period Prior to 10/01	Hospi tal Peri od On/After 10/01	PPS Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.
01	payments DRG amounts other than outlier payments for discharges	1.01	2, 993, 580	0	2, 993, 58	0	2, 993, 580	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	8, 319, 055	0		8, 319, 055	8, 319, 055	1.
)3	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1.03	0	0		0	0	1.
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00						2
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	57, 128	0	57, 12	8	57, 128	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	36, 882	0		36, 882	36, 882	2
00	Operating outlier reconciliation	2.01	0	0		0 0	0	3
00	Managed care simulated payments	3.00	0	0		0 0	0	4.
00	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 00000	0 0.00000		5.
0	IME payment adjustment (see instructions)	22.00	0	0		0 0	0	6
)1	IME payment adjustment for managed care (see instructions)	22.01	0	0		0 0	0	6
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ection 422 of	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000			0 0. 000000		7
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9
00	Disproportionate Share Adjustme		0.1/					
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1657	0. 1657	0. 165	0. 1657		10
00	Disproportionate share adjustment (see instructions)	34.00	468, 626	0	124, 00	9 344, 617	468, 626	11
01	Uncompensated care payments Additional payment for high per	36.00 rcentage of ES	2, 497, 915 RD beneficiary	0 di scharges	577, 72	9 1, 920, 186	2, 497, 915	11
00	Total ESRD additional payment	46.00	0	0		0 0	0	12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	14, 373, 186 0	0 0	3, 752, 44	6 10, 620, 740 0 0	14, 373, 186 0	
00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient	49.00	14 272 104	0	3 750 11	6 10 620 740	14, 373, 186	15
υU	lotal payment for inpatient operating costs (see instructions)	49.UU	14, 373, 186	0	3, 752, 44	6 10, 620, 740	14, 373, 186	

	Financial Systems		MARI ON GENERA	Provider C	CN: 15-0011	Period: From 07/01/2019 To 06/30/2020		t 4 pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	927, 543	0			927, 543	16.00
17.00	Special add-on payments for new technologies	54.00	0	0		0 0	0	17.00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.0 [°] 17.02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
19.00	SUBTOTAL			0	4,009,90	11, 290, 825	15, 300, 729	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	902, 996 0	0		70 659, 426 0 0	902, 996 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2.00 2.01	24, 547 0	0 0		38 10, 659 0 0	24, 547 0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000				22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	927, 543	0	257, 45	670, 085	927, 543	26.00
		W/S E, Part A						
		line	E, Part A)	2.00	2.00	4.00	F 00	
27.00	Low valume adjustment footor	0	1.00	2.00	3.00	4.00	5.00	27.00
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 00000	0 0. 000000 0	0	27.00 28.00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100. 00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

1.01 DRC anounts other than outlier payments for discharges occurring prior to 0 totaber 1 1.01 2.993.580 2.992.580 2.993.580 1 1.02 DRC anounts other than outlier payments for discharges occurring prior to 0 totaber 1 1.02 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 1.02 0.01 0 0 0 1.02 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 1.02 0.01 0 0 0 1.02 0.01 0 0 0 0 1.02 0.01 0		Financial Systems	MARION GENER			In Lie	u of Form CMS-2	2552-10
The set of	HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	5 Provider C	F	rom 07/01/2019	Part A Exhibi	
Image: Second					T	0 06/30/2020	Date/Time Pre 11/20/2020 1:	pared: 17 pm
A. Line West. E, PL. 10/01 after 10/01 2 and 3) 1.00 BBG means other than outling payments for discharges occurring prior to Detater 1 1.00 2.00 3.00 4.00 1 1.01 BBG means other than outling payments for discharges occurring on or after October 1 1.02 8.319.055 8.3							PPS	•
DC DK anounts other than outlier payments 0 1.00 2.00 3.00 4.00 1.00 DKS anounts other than outlier payments for 1.01 2.993.980 2.993.980 2.993.980 2.993.980 2.993.980 2.993.980 1 1.01 DKS anounts other than outlier payments for 1.02 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 8.319.055 1 1.02 DKS for Federal specific operating payment for Model 4 BRC occurring on rafter 0 0 0 0 0 0 0 2 2 0 0 0 2 2 2 0 0 0 2 2 2 0 0 0 2 2 2 0 0 0 2 2 2 0				Wkst. E, Pt.			``	
1.00 DKG amounts other than outlier payments of ischarges occurring prior to October 1 (accharges occurring prior to October 1 to UKG amounts other than outlier payments for discharges occurring prior to October 1 for Model 4 BPCL occurring prior to October 1 for Model 4 BPCL occurring prior to October 1. 1.01 2, 993, 580 2, 993, 580 2, 993, 580 2, 993, 580 0 0 1.00 UKG amounts other than outlier payments for discharges occurring prior to October 1. 1.02 8, 319, 055 8, 319, 055 8, 319, 055 8, 319, 055 8, 319, 055 8, 319, 055 8, 319, 055 0 <t< td=""><td></td><td></td><td>0</td><td></td><td>2.00</td><td>3.00</td><td>4,00</td><td></td></t<>			0		2.00	3.00	4,00	
discharges occurring prior to October 1 1.02 BRG anounts other than outli or payments for indiraction of the payment is for after October 1 1.03 Construction of the payment is for indiraction of the payment is or thodel 4 BPC1 occurring on or after October 1 1.03 Obs for Foderal specific operating payment 1.02 2.03 Outlier payments for discharges (see 1.04 0.0 Ottober 1 0.0 Ottober 1 1.04 BC instructions) 0.0 Outlier payments for discharges (see 1.02 0.0 Utilier payments for discharges occurring 2.03 Outlier payments for discharges occurring 0.0 0	1.00	DRG amounts other than outlier payments	1.00					1.00
1.02 DBG amounts other than outlier payments for discharges occurring on or after to October 1 1.03 0 0 10 10 1.03 DBG for Federal specific operating payment for Model 4 BPCI occurring on on after October 1 1.04 0<	1. 01		1. 01	2, 993, 580	2, 993, 580		2, 993, 580	1.01
1.03 DBC for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 monstructions for discharges (see Detober 1 monstructions) 1.03 0 0 0 1 2.00 DBC for Federal specific operating payment October 1 monst for discharges (see Detober 1 monst for discharges (see Detober 1 monst for discharges courring prior to October 1 (see instructions) 1.04 0 0 0 2 2.01 Outlier payments for discharges cocurring prior to October 1 (see instructions) 2.02 0 0 0 0 2 3.00 Operating outlier recenciliation 2.01 0	1. 02	DRG amounts other than outlier payments for	1. 02	8, 319, 055		8, 319, 055	8, 319, 055	1.02
for Model 4 BPCI occurring on or after October 1 c <thc< th=""> c c c</thc<>	1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1.03
October 1 Constructions Construction	1. 04		1.04	0		0	0	1.04
Instructions) Instructions) Instructions) 0	2.00	October 1	2.00					2.00
BPC1 Description BPC1 For the payments for discharges occurring 2.03 57,128 57,128 57,128 2 2.03 Outpiner payments for discharges occurring on 2.04 36,882		instructions)						2.00
prior to Cotober 1 (see instructions) 2.04 36,882 36,812 36	2. 01		2. 02	0	0	0	0	2.01
or after of tober 1 (see instructions) 2.01 0	2.02		2.03	57, 128	57, 128		57, 128	2.02
3.00 Operating outlier reconciliation 2.01 0	2.03		2.04	36, 882		36, 882	36, 882	2.03
Indiffect Medical Education Adjustment Image: Construction of the second s		Operating outlier reconciliation			-	-		3.00 4.00
5.00 Amount from Worksheet E, Part A, Line 21 (See instructions) 21.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000 0.0000 0.00000	4.00		3.00		0	0	0	4.00
6.00 IME payment adjustment (see instructions) 22.00 0	5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 000000	0. 000000		5.00
instructions) o IME payment adjustment factor (see 27.00 0.00000000 0.00000000000 0.00000000000000000000000000000000000		IME payment adjustment (see instructions)			-	-		6.00
7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 0.000000 7 8.00 IME adjustment (see instructions) 28.00 0 <td>0.01</td> <td>instructions)</td> <td></td> <td>_</td> <td></td> <td>0</td> <td>0</td> <td>6. 01</td>	0.01	instructions)		_		0	0	6. 01
instructions) 28.00 0	7 00					0,000000		7.00
8.01 IME payment adjustment add on for managed care (see instructions) 28.01 0	7.00		27.00	0.000000	0.000000	0.000000		7.00
care (see instructions) o								8.00
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 0	8. 01		28. 01	0	0	0	0	8. 01
Lines 6.01 and 8.01) Disproportionate Share Adjustment Disproportionate Share Adjustment 33.00 0.1657 0.1657 0.1657 10.00 Allowable disproportionate share percentage (see instructions) 33.00 0.1657 0.1657 0.1657 11.00 Disproportionate share adjustment (see 34.00 468.626 124.009 344.617 468.626 11 11.01 Uncompensated care payments 36.00 2.497,915 577,729 1,920,186 2,497,915 11 Additional payment for high percentage of ESRD beneficiary discharges 11.01 Uncompensated care payment (see 46.00 0 0 0 12 13.00 Subtotal (see instructions) 47.00 14,373,186 3,752,446 10,620,740 14,373,186 13 14.00 and MDH, small rural hospitals only.) (see instructions) 14.00 14,373,186 3,752,446 10,620,740 14,373,186 15 15.00 Total payment for inpatient operating costs 49.00 14,373,186 3,752,446 10,620,740 14,373,186 14 16.00		Total IME payment (sum of lines 6 and 8)		-	-	0		9.00 9.01
10.00 Allowable disproportionate share percentage (see instructions) 33.00 0.1657 0.1657 0.1657 0.1657 10 11.00 Disproportionate share adjustment (see instructions) 34.00 468,626 124,009 344,617 468,626 11 11.01 Uncompensated care payments 36.00 2,497,915 577,729 1,920,186 2,497,915 11 Additional payment for high percentage of ESRD beneficiary discharges 10 0 0 0 0 12 13.00 Subtotal (see instructions) 47.00 14,373,186 3,752,446 10,620,740 14,373,186 13 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 49.00 14,373,186 3,752,446 10,620,740 14,373,186 15 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,373,186 3,752,446 10,620,740 14,373,186 16 Wst. L, Pt. I, if applicable) 50.00 927,543 257,458 670,085 927,543 16 17.00 Special add-on payments for new technologies 54.00 0 0 <td>7.01</td> <td>lines 6.01 and 8.01)</td> <td>27.01</td> <td></td> <td></td> <td></td> <td></td> <td>7.01</td>	7.01	lines 6.01 and 8.01)	27.01					7.01
(see instructions) (see instructions) 11.00 Disproportionate share adjustment (see 34.00 468,626 124,009 344,617 468,626 11 11.01 Uncompensated care payments 36.00 2,497,915 577,729 1,920,186 2,497,915 11 Additional payment for high percentage of ESRD beneficiary discharges 12 0 Total ESRD additional payment (see 46.00 0 0 0 12 13.00 Subtotal (see instructions) 47.00 14,373,186 3,752,446 10,620,740 14,373,186 13 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 14 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 14 14 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,373,186 3,752,446 10,620,740 14,373,186 15 16.00 Payment for inpatient program capital (from %50.00 927,543 257,458 670,085 927,543 16 <t< td=""><td>10 00</td><td></td><td>22.00</td><td>0 1457</td><td>0 1457</td><td>0 1457</td><td></td><td>10 00</td></t<>	10 00		22.00	0 1457	0 1457	0 1457		10 00
instructions) 36.00 2,497,915 577,729 1,920,186 2,497,915 11 Additional payment for high percentage of ESRD beneficiary discharges 46.00 0 0 0 12 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12 13.00 Subtotal (see instructions) 47.00 14,373,186 3,752,446 10,620,740 14,373,186 13 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 0 14 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,373,186 3,752,446 10,620,740 14,373,186 15 (see instructions) 15.00 Total payment for inpatient operating costs 49.00 14,373,186 3,752,446 10,620,740 14,373,186 15 (see instructions) 15.00 Total payment for inpatient operating costs 49.00 9.00 927,543 257,458 670,085 927,543 16 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 17		(see instructions)						10.00
Addi ti onal payment for high percentage of ESRD beneficiary discharges12.00Total ESRD addi ti onal payment (see instructi ons)46.00 00001213.00Subtotal (see instructi ons)47.0014,373,1863,752,44610,620,74014,373,1861314.00Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)47.0014,373,1863,752,44610,620,74014,373,1861415.00Total payment for inpatient operating costs (see instructions)49.0014,373,1863,752,44610,620,74014,373,1861516.00Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)50.00927,543257,458670,085927,5431617.00Special add-on payments for new technologies replaced devices for applicable MS-DRGs68.00000001718.00Capital outlier reconciliation adjustment93.000000000	11.00		34.00	468, 626	124, 009	344, 617	468, 626	11.00
12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 12 13.00 Subtotal (see instructions) 47.00 14,373,186 3,752,446 10,620,740 14,373,186 13 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 0 0 0 0 0 0 14,373,186 13,752,446 10,620,740 14,373,186 13 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,373,186 3,752,446 10,620,740 14,373,186 15 16.00 Payment for inpatient program capital (from WKst. L, Pt. I, if applicable) 50.00 927,543 257,458 670,085 927,543 16 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17 17.01 Net organ acquisition cost 17 68.00 0 0 0 0 17 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 0 18.00	11.01				577, 729	1, 920, 186	2, 497, 915	11.01
13.00 Subtotal (see instructions) 47.00 14,373,186 3,752,446 10,620,740 14,373,186 13 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 0 0 0 0 14 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,373,186 3,752,446 10,620,740 14,373,186 15 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 927,543 257,458 670,085 927,543 16 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 17 18.00 Capital outlier reconciliation adjustment 93.00 0 <t< td=""><td>12.00</td><td>Total ESRD additional payment (see</td><td></td><td></td><td>0</td><td>0</td><td>0</td><td>12.00</td></t<>	12.00	Total ESRD additional payment (see			0	0	0	12.00
and MDH, small rural hospitals only.) (see instructions)15.00Total payment for inpatient operating costs (see instructions)15.00Total payment for inpatient operating costs (see instructions)16.00Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)17.00Special add-on payments for new technologies or cost17.01Net organ acquisition cost17.02Credits received from manufacturers for replaced devices for applicable MS-DRGs18.00Capital outlier reconciliation adjustment93.000	13.00	Subtotal (see instructions)		14, 373, 186	3, 752, 446	10, 620, 740	14, 373, 186	13.00
15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,373,186 3,752,446 10,620,740 14,373,186 15 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 927,543 257,458 670,085 927,543 16 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17 17.01 Net organ acquisition cost 68.00 0 0 0 0 17 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 0	14.00	and MDH, small rural hospitals only.) (see	48.00	0	0	0	0	14.00
16.00Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)50.00927,543257,458670,085927,5431617.00Special add-on payments for new technologies54.0000001717.01Net organ acquisition cost54.000001717.02Credits received from manufacturers for replaced devices for applicable MS-DRGs68.0000001718.00Capital outlier reconciliation adjustment93.000000018	15.00	Total payment for inpatient operating costs	49.00	14, 373, 186	3, 752, 446	10, 620, 740	14, 373, 186	15.00
17.00Special add-on payments for new technologies54.000001717.01Net organ acquisition cost1717171717.02Credits received from manufacturers for replaced devices for applicable MS-DRGs68.0000001718.00Capital outlier reconciliation adjustment93.000000018	16.00	Payment for inpatient program capital (from	50.00	927, 543	257, 458	670, 085	927, 543	16.00
17. 02Credits received from manufacturers for replaced devices for applicable MS-DRGs68. 000001718. 00Capital outlier reconciliation adjustment93. 000000018		Special add-on payments for new technologies	54.00	0	0	0	0	17.00 17.01
18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 0 18		Credits received from manufacturers for	68.00	0	0	0	0	
amount (see instructions)	18.00	Capital outlier reconciliation adjustment	93.00	0	0	0	0	18.00
19.00 SUBTOTAL 4,009,904 11,290,825 15,300,729 19	19.00				4, 009, 904	11, 290, 825	15, 300, 729	19.00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/20/2020 1:	pared:
				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	902, 996	243, 57		902, 996	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	24, 547	13, 88	10, 659	24, 547	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	927, 543	257, 45	670, 085	927, 543	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00 28.00 29.00 30.00 30.01	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1 HVBP payment adjustment (see instructions) HVBP payment adjustment for HSP bonus payment (see instructions)	70. 96 70. 97 70. 93 70. 90	0 0 61, 917 0	17, 82	0 04 0 0 0 0	0 0 61, 917 0	29.00 30.00
31. 00 31. 01	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-17, 669 0	-2,69	04 -14, 975 0 0	-17, 669 0	
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99		40, 25	113, 199	153, 449	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

	Financial Systems MARION GENERAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0011	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
			From 07/01/2019 To 06/30/2020		pared:
				11/20/2020 1:	
		Title XVIII	Hospi tal	PPS	
				1.00	
. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			1, 184	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	ctions)		18, 984, 654	
3.00	OPPS payments			16, 971, 754	
I. 00 I. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			84, 267 0	
5.00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
o. 00	Line 2 times line 5			0	
7.00 3.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
0.00	Organ acquisitions			0	10.00
1.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 184	11.00
	Reasonable charges				
2.00	Ancillary service charges			6, 258	12.00
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			6, 258	14.00
5.00	Aggregate amount actually collected from patients liable for	payment for services or	n a charge basis	0	15.00
6.00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16.00
7.00	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0. 000000	17 00
8.00	Total customary charges (see instructions)			6, 258	
9.00	Excess of customary charges over reasonable cost (complete o	nly if line 18 exceeds l	ine 11) (see	5, 074	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete ou	nlvifline 11 exceeds l	ine 18) (see	0	20.00
.0.00	instructions)		1110 10) (300	0	20.00
21.00	Lesser of cost or charges (see instructions)			1, 184	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see ins	tructions)		0	22.00 23.00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructrons)		17, 056, 021	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	ructions)	1 3, 245, 137	25.00 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			13, 812, 067	
	instructions)				
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29))		13, 812, 067	
	Primary payer payments			1, 772	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	ICES)		13, 810, 295	32.00
3. 00	Composite rate ESRD (from Wkst. I-5, line 11)	1020)		0	33.00
	Allowable bad debts (see instructions)			597, 011	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		388, 057 349, 116	
37.00	Subtotal (see instructions)	ti de ti ons)		14, 198, 352	
8. 00	MSP-LCC reconciliation amount from PS&R			4	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	nc)		0	39.00 39.50
39.30 39.97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for repla		uctions)	3, 200	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
0.00 0.01	Subtotal (see instructions) Sequestration adjustment (see instructions)			14, 198, 348 237, 112	
0.02	Demonstration payment adjustment amount after sequestration			0	1
0. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
1.00 1.01	Interim payments Interim payments-PARHM			14, 077, 947	41.00 41.0
12.00	Tentative settlement (for contractors use only)			0	
2. 01	Tentative settlement-PARHM (for contractor use only)				42. O
3.00 3.01	Balance due provider/program (see instructions)			-116, 711	
4.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2	chapter 1.	0	43.01 44.00
	§115. 2		· · · · · · · · · · · · · · · · · · ·		
0.00	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	
4.00	Total (sum of lines 91 and 93)			0	94.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0011	Period: From 07/01/2019 To 06/30/2020) Date/Time Pre	pare
		Ti ti o	XVIII	Hospi tal	11/20/2020 1: PPS	1/p
			t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		12, 980, 9		13, 576, 213	1.
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	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.
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	06/30/2020	115, 9		501, 734	3.
02				0	0	3
03				0	0	3
04 05				0	0	3
00	Provider to Program			0	0	1 3
50	ADJUSTMENTS TO PROGRAM			0	0	1 3
51				0	0	3
52				0	0	3
53				0	0	3
54			115 0	0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		115, 9	09	501, 734	3
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)		13, 096, 8	19	14, 077, 947	4
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
21	Program to Provider TENTATIVE TO PROVIDER	1	-	0	0	1 -
01 02	IENTATIVE TO PROVIDER			0	0	5
02				0	0	
	Provider to Program	1			-	
50	TENTATI VE TO PROGRAM			0	0] 5
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		398, 8	99	0	6
02	SETTLEMENT TO PROGRAM		570,0	0	116, 711	6
00	Total Medicare program liability (see instructions)		13, 495, 7	18	13, 961, 236	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	8

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0011 CCN: 15-T011	Period: From 07/01/2019 To 06/30/2020	Worksheet E- Part I Date/Time Pre 11/20/2020 1:	epared
		Title	e XVIII	Subprovider - IRF	PPS	<u> </u>
		Inpatier	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00 3,794,7	3.00	4.00	1.
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		3, 774, 7	0	C	
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.
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3.
01				0		
03				0	0	
04				0	C	-
05				0	C) 3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	C	3
50 51	ADJUSTIMENTS TO PROGRAM			0		
52				0		
53				0	C	3 3
54				0	C	-
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	C	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		3, 794, 7	77	C	4
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1		1	Η.,
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		1		-	
01	TENTATI VE TO PROVI DER			0	C	
02 03				0		
55	Provider to Program			0		4 3
50	TENTATI VE TO PROGRAM			0	C	5
51				0	C	
52				0	C	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	C	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		20, 1	13	C	
02	SETTLEMENT TO PROGRAM		2 014 0	0	C	
00	Total Medicare program liability (see instructions)		3, 814, 89	20 Contractor	NPR Date) 7
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	

Heal th	Financial Systems MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS	-2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0011	Period: From 07/01/2019 To 06/30/2020		epared:	
		Title XVIII	Hospi tal	PPS	<u>. 17 piii</u>	
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				1.00	
1.00						
2.00						
3.00						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (see instructions)				8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	· · ·				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00	
			· · ·		•	

		ERAL HOSPITAL		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0011	Period: From 07/01/2019	Worksheet E-3 Part III	
		Component CCN: 15-T011	To 06/30/2020	Date/Time Pre	
		Title XVIII	Subprovi der -	11/20/2020 1: PPS	1/ p
			I RF		
				1.00	
. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)			3, 815, 164	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0285	2.
00	Inpatient Rehabilitation LIP Payments (see instructions)			103, 391	3
00	Outlier Payments			28, 028	4
00	Unweighted intern and resident FTE count in the most rece	ent cost reporting period e	ndina on or prior	0.00	5
	to November 15, 2004 (see instructions)	5 1	J		
01	Cap increases for the unweighted intern and resident FTE	count for residents that we	re displaced by	0.00	5
	program or hospital closure, that would not be counted wi	ithout a temporary cap adjus	tment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth	period of a "new	0.00	7
~~	teaching program" (see instructions)			0.00	
00	Current year's unweighted I&R FTE count for residents wi	thin the new program growth	period of a "new	0.00	8
00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education a	adjustment (see instructions		0.00	9
00	Average Daily Census (see instructions))	7. 281421	10
. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
2.00	Teaching Adjustment (see instructions)			0.000000	12
. 00	Total PPS Payment (see instructions)			3, 946, 583	13
1.00	Nursing and Allied Health Managed Care payments (see ins	truction)		0,000	14
5.00	Organ acquisition (DO NOT USE THIS LINE)			-	15
b. 00	Cost of physicians' services in a teaching hospital (see	instructions)		0	
. 00	Subtotal (see instructions)	,		3, 946, 583	17
3. 00	Primary payer payments			0	18
0. 00	Subtotal (line 17 less line 18).			3, 946, 583	19
. 00	Deductibles			63, 492	20
. 00	Subtotal (line 19 minus line 20)			3, 883, 091	
2.00	Coinsurance			3, 410	
3.00	Subtotal (line 21 minus line 22)			3, 879, 681	23
1.00		services) (see instructions)		0	24
5.00	Adjusted reimbursable bad debts (see instructions)			0	25
b. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	26
7.00	Subtotal (sum of lines 23 and 25)	4 1		3, 879, 681	27
3.00 7.00	Direct graduate medical education payments (from Wkst. E-	-4, ITHE 49)		0	28
). 00	Other pass through costs (see instructions) Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
1.50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	31
1.99	Demonstration payment adjustment amount before sequestra			0	31
2.00	Total amount payable to the provider (see instructions)			3, 879, 681	
2. 01	Sequestration adjustment (see instructions)			64, 791	
2. 02	Demonstration payment adjustment amount after sequestration	i on		0	
3.00	Interim payments			3, 794, 777	33
1.00	Tentative settlement (for contractor use only)			0	34
5.00	Balance due provider/program (line 32 minus lines 32.01,	32.02, 33, and 34)		20, 113	35
6. 00	Protested amounts (nonallowable cost report items) in accession	cordance with CMS Pub. 15-2,	chapter 1,	0	36
	§115.2 TO BE COMPLETED BY CONTRACTOR				
D. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			28, 028	50
1.00	Outlier reconciliation adjustment amount (see instruction	ns)		0	51
2 00	The rate used to calculate the Time Value of Money			0.00	52
2.00					53

CALCUI		OSPITAL Provider CCN: 15-0011	Peri od:	Worksheet E-3	2552-10
0/12002			From 07/01/2019 To 06/30/2020	Part VII	pared:
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR 2	XIX SERVICES		-
1.00	COMPUTATION OF NET COST OF COVERED SERVICES		1 074 259		1 1 00
2.00	Medical and other services		1, 074, 358	0	1.00
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 074, 358	0	1
5.00	Inpatient primary payer payments		0	-	5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 074, 358	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		1, 003, 151		8.00
9.00	Ancillary service charges		1, 960, 555	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00 12.00	Incentive from target amount computation		2 042 704	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		2, 963, 706	0	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
15.00	basi s	services on a charge	Ŭ	0	15.00
14.00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14.00
	a charge basis had such payment been made in accordance with 4				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15.00	
16.00	Total customary charges (see instructions)		2, 963, 706	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	1, 889, 348	0	17.00	
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18.00
10.00	16) (see instructions)			0	10.00
19.00 20.00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	
20.00	Cost of covered services (enter the lesser of line 4 or line 1		1, 074, 358	0	1
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
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		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		1, 074, 358	0	29.00
~~ ~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 074, 358	0	
32.00	Deducti bl es Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	•	34.00
35.00	Utilization review	0	0	34.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1, 074, 358	0	1	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37.00
38.00	Subtotal (line 36 ± line 37)			0	
39.00	Direct graduate medical education payments (from Wkst. E-4)			Ũ	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1, 074, 358	0	1
41.00	Interim payments		1, 956, 046	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-881, 688	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				1

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2019	Worksheet E-3 Part VII	\$
		Component CCN: 15-T011	To 06/30/2020	Date/Time Pre 11/20/2020 1:	
		Title XIX	Subprovider - IRF	Cost	
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	ERVICES FOR TITLES V OR	1.00	2.00	+
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		28, 076		1 ·
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		:
00	Subtotal (sum of lines 1, 2 and 3)		28, 076	0	
00	Inpatient primary payer payments		0	0	
00 00	Outpatient primary payer payments		20.074	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		28, 076	0	1
	Reasonable Charges				1
00	Routi ne servi ce charges		31, 925		8
00	Ancillary service charges		45, 204	0	
. 00	Organ acquisition charges, net of revenue		0		1(
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		77, 129	0	1:
	CUSTOMARY CHARGES	- · ·			4.
. 00	Amount actually collected from patients liable for payment f	for services on a charge	0	0	1:
00	basis		0	1	
. 00	Amounts that would have been realized from patients liable f	on 0	0	14	
. 00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000	1
. 00	Total customary charges (see instructions)			0	
. 00	xcess of customary charges over reasonable cost (complete only if line 16 exceeds			0	
	line 4) (see instructions)	49, 053			
. 00	Excess of reasonable cost over customary charges (complete o	only if line 4 exceeds li	ne 0	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see ins		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b		28,076	0	2'
. 00	Other than outlier payments	e compreted for PPS prov	0	0	2
. 00	Outlier payments		0	0	
. 00	Program capital payments		0	0	2
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	2
. 00	Subtotal (sum of lines 22 through 26)		0	0	2
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		28, 076	0	20
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		-		4
. 00	Excess of reasonable cost (from line 18)	~	0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	0)	28, 076	0	
. 00	Deducti bl es Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 00	Subtotal (line 36 ± line 37)			0	
	Direct graduate medical education payments (from Wkst. E-4)		28, 076 0		3
. 00	Total amount payable to the provider (sum of lines 38 and 39	2)	28, 076	0	4
. 00	Interim payments		17, 740	0	
. 00	Balance due provider/program (line 40 minus line 41)		10, 336	0	
3.00	Protested amounts (nonallowable cost report items) in accord	lance with CMS Pub 15-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column		F T	Period: rom 07/01/2019 o 06/30/2020	11/20/2020 1:	pared: <u>17 pm</u>
		General Fund	Speci fi c Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	36, 653, 746	C	0	0	1.00
. 00	Temporary investments	0			0	2.00
. 00	Notes receivable	0	, i i i i i i i i i i i i i i i i i i i	-	0	3.00
. 00	Accounts receivable	57, 423, 541		-	0	4.00
. 00 . 00	Other receivable Allowances for uncollectible notes and accounts receivable	3, 634, 855 -34, 719, 717			0	5.00 6.00
. 00	Inventory	2, 264, 928		-	0	7.00
. 00	Prepaid expenses	2, 400, 003		0	0	8.0
. 00	Other current assets	872, 264	0	0	0	9.0
	Due from other funds	0	, °		0	10.0
	Total current assets (sum of lines 1-10)	68, 529, 620	C	0	0	11.0
	FI XED ASSETS Land	5, 191, 829		0	0	12.0
	Land improvements	3, 353, 531			0	13.00
	Accumulated depreciation	-2, 958, 310			0	14.00
	Buildings	142, 659, 238			0	15.0
	Accumulated depreciation	-86, 215, 059			0	16.0
7.00	Leasehold improvements	3, 756, 061	0	0	0	17.0
	Accumulated depreciation	-3, 015, 667		-	0	18.0
	Fixed equipment	3, 509, 530		-	0	19.0
	Accumulated depreciation	-1, 139, 248		-	0	20.0
	Automobiles and trucks Accumulated depreciation	1, 059, 245 -794, 629		-	0	21.0 22.0
	Major movable equipment	72, 943, 656			0	22.0
	Accumulated depreciation	-60, 786, 612		-	0	24.0
	Minor equipment depreciable	0	0		0	25.0
5.00	Accumulated depreciation	0	C	0	0	26.0
	HIT designated Assets	0	C	-	0	27.0
	Accumulated depreciation	0	0	-	0	28.0
	Minor equipment-nondepreciable	447,636			0	29.0
	Total fixed assets (sum of lines 12-29) OTHER ASSETS	78, 011, 201		0	0	30.0
	Investments	259, 954, 827	C	0	0	31.0
2.00	Deposits on leases	0		0	0	32.0
	Due from owners/officers	0	C	-	0	33.0
	Other assets	14, 763, 315		-	0	34.0
	Total other assets (sum of lines 31-34)	274, 718, 142			0	35.0
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	421, 258, 963	C	0	0	36.0
	Accounts payable	5, 105, 279	C	0	0	37.0
	Salaries, wages, and fees payable	8, 460, 371			0	38.0
9.00	Payroll taxes payable	0	C	0	0	39.0
	Notes and loans payable (short term)	0	C	0	0	
	Deferred income	0	C	0	0	41.0
	Accelerated payments	0			0	42.0
	Due to other funds Other current liabilities	27, 005, 110		°	0	43.C
	Total current liabilities (sum of lines 37 thru 44)	40, 570, 760			0	45.0
0.00	LONG TERM LIABILITIES	10,010,100				1010
6.00	Mortgage payable	0	C	0	0	46. C
7.00	Notes payable	0	C	0	0	47.0
	Unsecured Loans	0	C	-	0	48.0
	Other long term liabilities	81, 401, 314			0	49.0
	Total long term liabilities (sum of lines 46 thru 49)	81, 401, 314			0	50.0
1.00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	121, 972, 074		0	0	51.0
2.00	General fund balance	299, 286, 889				52.0
	Specific purpose fund	2,7,200,00,	c c			53.0
	Donor created - endowment fund balance - restricted			0		54.0
5.00	Donor created - endowment fund balance - unrestricted			0		55.0
	Governing body created - endowment fund balance			0		56.
	Plant fund balance - invested in plant				0	57.0
3. 00	Plant fund balance - reserve for plant improvement,				0	58.0
00	replacement, and expansion Total fund balances (sum of lines 52 thru 59)	200 204 000			0	50
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	299, 286, 889 421, 258, 963		0	0	59. 60.

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL		In L	eu of Form CMS	6-2552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0011	Period: From 07/01/20 To 06/30/20	20 Date/Time P	repared:
		General	Fund	Speci al	Purpose Fund	11/20/2020 Endowment Fund	1:17 pm
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund 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) ROUND Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	292, 793, 930 6, 492, 956 299, 286, 886 33 299, 286, 889 0 299, 286, 889	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	$\begin{array}{c c} 1.00\\ 2.00\\ 3.00\\ 0 4.00\\ 0 5.00\\ 0 5.00\\ 0 6.00\\ 0 7.00\\ 0 8.00\\ 0 9.00\\ 10.00\\ 11.00\\ 0 12.00\\ 0 12.00\\ 0 13.00\\ 0 14.00\\ 0 15.00\\ 0 16.00\\ 0 17.00\\ 18.00\\ 19.00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund	_		
1 00	Fund halanage at heginning of paried	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	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) ROUND	0	0 0 0 0 0		0		$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00 \end{array} $
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 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

TATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	I: 15-0011	Period: From 07/01/2019 To 06/30/2020	Worksheet G-2 Parts I & II Date/Time Pre 11/20/2020 1:	pared
	Cost Center Description		I npati ent	Outpati ent	Total	· ·
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
. 00	Hospi tal		16, 018, 37	76	16, 018, 376	1.0
. 00	SUBPROVIDER - IPF			0	0	2.0
. 00	SUBPROVIDER - IRF		3, 401, 92	28	3, 401, 928	3.0
. 00	SUBPROVI DER			0	0	4.0
. 00	Swing bed - SNF			0	0	5.0
. 00	Swing bed - NF			0	0	6.0
. 00	SKILLED NURSING FACILITY					7.0
. 00	NURSING FACILITY					8.0
. 00	OTHER LONG TERM CARE					9.0
0.00	Total general inpatient care services (sum of lines 1-9)		19, 420, 30	74	19, 420, 304	
0.00	Intensi ve Care Type Inpatient Hospital Services		17, 120, 00		17, 120, 001	1 10.0
1.00	INTENSIVE CARE UNIT		5, 983, 59	92	5, 983, 592	11. C
2.00	CORONARY CARE UNIT		0, 700, 0	/2	0, 700, 072	12.0
	BURN INTENSIVE CARE UNIT					13.0
	SURGI CAL I NTENSI VE CARE UNI T					14.0
	OTHER SPECIAL CARE (SPECIFY)					14.0
	Total intensive care type inpatient hospital services (sum of	Lines		11	E 002 E02	
0.00	11-15)	TTHES	5, 983, 59	92	5, 983, 592	10.1
7.00	Total inpatient routine care services (sum of lines 10 and 16)		25, 403, 89	74	25, 403, 896	17.0
8.00	Ancillary services				75, 710, 573	
9.00	Outpatient services		75, 710, 57			
					356, 141, 817	
0.00	RURAL HEALTH CLINIC			0 0	0	20.0
	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
2.00	HOME HEALTH AGENCY			0 4 454 570	4 454 570	22.0
3.00	AMBULANCE SERVICES			0 4, 451, 579	4, 451, 579	
						24.0
5.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
6.00	HOSPICE					26.0
7.00	PROFESSIONAL FEES			0 63, 265, 875	63, 265, 875	
8.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	101, 114, 46	69 423, 859, 271	524, 973, 740	28.0
	G-3, line 1)					
	PART II - OPERATING EXPENSES			101 000 040		
9.00	Operating expenses (per Wkst. A, column 3, line 200)		1 000 5	191, 238, 240		29.0
0.00	ELI MI NATI ONS		-1, 029, 50			30.0
1.00				0		31.0
2.00				0		32.0
3.00				0		33.
4.00				0		34.0
5.00				0		35.0
6.00	Total additions (sum of lines 30-35)			-1, 029, 506		36.0
7.00	DEDUCT (SPECIFY)			0		37.
8.00				0		38.
9.00				0		39.
0.00				0		40.
1.00				0		41.
2.00	Total deductions (sum of lines 37-41)			0		42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		190, 208, 734		43.0
	to Wkst. G-3, line 4)					

STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0011 Period: From 07/01/2019 To 06/30/2020 Worksheet G-3 Date/Time Prepared: 11/20/2020 1:17 pm 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 524,973,740 1.00 2.00 Less contractual allowances and discounts on patients' accounts 341.311,020 2.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 190,208,734 4.00 0.01 Less total operating expenses (from Wkst. G-2, Part II, line 43) 190,208,734 4.00 0.01 Income from investments 0 6.00 0 1.00 0.00 Periodic from investments 0 6.00 0 0 0.00 Revenues from telephone and other miscellaneous communication services 0 6.100 0 0.00 Purchase discounts 0 11.00 0 11.00 0 1.00 Parting lot receipts 0 0 0 0 0 0 0 10.00 1.00 Perioas discounts 0 11.200 0 11.200 0 11.00<	Heal th	Financial Systems	MARION GENERAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10		
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 524, 973, 740 1.00 2.00 Less contractual allowances and discounts on patients' accounts 341, 311, 020 2.00 3.00 Net patient revenues (line 1 minus line 2) 183, 662, 720 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 190, 208, 734 4.00 5.00 Net income from service to patients (line 3 minus line 4) -6, 546, 014 5.00 0THER INCOME 6.00 Contributions, donations, bequests, etc 0 6.00 10.00 Purchase discounts 6.199, 840 7.00 8.00 8.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 10.00 Revenue from television and radio service 0 11.00 11.00 Revenue from meals of to employees and guests 0 12.00 11.00 Revenue from sale of medical and surgical supplies to other than patients 0 14.00 12.00 Revenue from sale of medical records and abstracts 0 15.00	STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-0011	From 07/01/2019	Date/Time Pre	pared:	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 524, 973, 740 1.00 2.00 Less contractual allowances and discounts on patients' accounts 341, 311, 020 2.00 3.00 Net patient revenues (line 1 minus line 2) 183, 662, 720 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 190, 208, 734 4.00 5.00 Net income from service to patients (line 3 minus line 4) -6, 546, 014 5.00 0THER INCOME 6.00 Contributions, donations, bequests, etc 0 6.00 10.00 Purchase discounts 6.199, 840 7.00 8.00 8.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 10.00 Revenue from television and radio service 0 11.00 11.00 Revenue from meals of to employees and guests 0 12.00 11.00 Revenue from sale of medical and surgical supplies to other than patients 0 14.00 12.00 Revenue from sale of medical records and abstracts 0 15.00								
2.00Less contractual allowances and discounts on patients' accounts341,311,0202.003.00Net patient revenues (line 1 minus line 2)183,662,7203.004.00Less total operating expenses (from Wkst. 6-2, Part II, line 43)190,028,7344.000.01Net income from service to patients (line 3 minus line 4)-6,546,0145.000.01Income from investments6,199,8407.008.00Revenues from telephone and other miscel aneous communication services06.009.00Revenues from telephone and other miscel aneous communication services09.009.00Revenue from television and radio service09.0010.00Parking lot receipts011.0010.00Revenue from meals sold to employees and guests012.0011.00Revenue from sale of medical and surgical supplies to other than patients014.0012.00Revenue from sale of medical and surgical supplies to other than patients017.0013.00Revenue from sale of textbooks, uniforms, etc.)019.0010.00Retat of choing and rines, coffee shops, and canteen022.0010.00Retat of hospital space022.0010.00Retat of hospital space022.0010.00Retat of hospital space022.0010.00Revenue from sale of medical records and abstracts018.0010.00Revenue from gifts, flowers, coffee shops, and canteen022.0010.00Revenu						1.00		
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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 6,748,959 24.00 24.50 COVID-19 PHE Funding 0 24.50 25.00 Total other income (sum of lines 6-24) 12,948,799 25.00 26.00 Total (line 5 plus line 25) 6,0402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00						0	15.00	
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 0 24.50 25.00 Total other income (sum of lines 6-24) 12, 948, 799 25.00 26.00 Total (line 5 pl us line 25) 6, 402, 785 26.00 27.00 BAD DEBT EXPENSE -90, 171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90, 171 28.00				han patients		0		
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 6,748,959 24.00 25.00 Total other income (sum of lines 6-24) 12,948,799 25.00 26.00 Total other splus line 25) 6,402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	17.00	Revenue from sale of drugs to other than	patients			0	17.00	
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 6,748,959 24.00 25.00 Total other income (sum of lines 6-24) 12,948,799 25.00 26.00 Total (line 5 plus line 25) 6,402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00						0		
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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 6,748,959 24.00 24.50 COVID-19 PHE Funding 0 24.50 25.00 Total other income (sum of lines 6-24) 12,948,799 25.00 26.00 Total (line 5 plus line 25) 6,402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	20.00	Revenue from gifts, flowers, coffee shops,	, and canteen			0	20.00	
23.00 Governmental appropriations 0 23.00 24.00 OTHER OPERATING REVENUE 6,748,959 24.00 24.50 COVID-19 PHE Funding 0 24.50 25.00 Total other income (sum of lines 6-24) 12,948,799 25.00 26.00 Total (line 5 plus line 25) 6,402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	21.00	Rental of vending machines				0	21.00	
24.00 OTHER OPERATING REVENUE 6,748,959 24.00 24.50 COVID-19 PHE Funding 24.50 25.00 Total other income (sum of lines 6-24) 12,948,799 25.00 26.00 Total (line 5 plus line 25) 6,402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	22.00	Rental of hospital space				0	22.00	
24. 50 COVI D-19 PHE Funding 0 24. 50 25. 00 Total other income (sum of lines 6-24) 12, 948, 799 25. 00 26. 00 Total (line 5 plus line 25) 6, 402, 785 26. 00 27. 00 BAD DEBT EXPENSE -90, 171 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) -90, 171 28. 00	23.00	Governmental appropriations				0	23.00	
25.00 Total other income (sum of lines 6-24) 12,948,799 25.00 26.00 Total (line 5 plus line 25) 6,402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	24.00	OTHER OPERATING REVENUE				6, 748, 959	24.00	
26.00 Total (line 5 plus line 25) 6,402,785 26.00 27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	24.50	COVI D-19 PHE Fundi ng				0	24.50	
27.00 BAD DEBT EXPENSE -90,171 27.00 28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	25.00	Total other income (sum of lines 6-24)				12, 948, 799	25.00	
28.00 Total other expenses (sum of line 27 and subscripts) -90,171 28.00	26.00	Total (line 5 plus line 25)				6, 402, 785	26.00	
	27.00	BAD DEBT EXPENSE				-90, 171	27.00	
20,00 Not income (or loss) for the period (line 26 minus line 20) $6,402,956$ 20,00	28.00	Total other expenses (sum of line 27 and s	subscripts)					
27.00 [Net theorem (01 1055) for the period (the 20 initial the 20) $0,492,930$ [29.00]	29.00	Net income (or loss) for the period (line	26 minus line 28)			6, 492, 956	29.00	

Health Financial Systems MARION GEI CALCULATION OF CAPITAL PAYMENT MARION GEI		Provider CCN: 15-0011	Period: From 07/01/2019	Worksheet L Parts I-III		
			To 06/30/2020			
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS		
				1.00		
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT					
00	Capital DRG other than outlier					
01	Model 4 BPCI Capital DRG other than outlier				1.	
00	Capital DRG outlier payments			24, 547	2.	
01	Model 4 BPCI Capital DRG outlier payments			0		
00	Total inpatient days divided by number of days in the co	st reporting period (see ins	tructions)	40. 08 0. 00		
00	Number of interns & residents (see instructions)					
00	Indirect medical education percentage (see instructions)		1	0.00		
00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)					
00	Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	0.00	7			
00					8	
00	Sum of lines 7 and 8				9	
					10	
	and the state of t				11	
. 00	Total prospective capital payments (see instructions)			927, 543	12	
				1.00		
~ ~	PART II - PAYMENT UNDER REASONABLE COST					
00	Program inpatient routine capital cost (see instructions			0		
00 00	5 1 5 1		0			
00				0		
00	Total inpatient program capital cost (line 3 x line 4)			0		
				1.00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00		
00	Program inpatient capital costs (see instructions)			0		
00	Program inpatient capital costs for extraordinary circum			0		
00	Net program inpatient capital costs (line 1 minus line 2))		0		
00	Applicable exception percentage (see instructions)	、 、		0.00		
00	Capital cost for comparison to payments (line 3 x line 4)			0 0.00		
00 00	Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraord	,	v line ()	0.00		
00	Capital minimum payment level (line 5 plus line 7)	That y circuits tances (The 2	x THE 0)	0		
00	Current year capital payments (from Part I, line 12, as a	applicable)		0		
. 00	Current year comparison of capital minimum payment level		less line 9)	0		
. 00	Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14)			0		
	Net comparison of capital minimum payment level to capita	al payments (line 10 plus li	ne 11)	0	12	
. 00				0	1	
	Current year exception payment (if line 12 is positive,					
. 00	Carryover of accumulated capital minimum payment level o	ver capital payment for the	following period	0	14	
3. 00 4. 00	Carryover of accumulated capital minimum payment level or (if line 12 is negative, enter the amount on this line)		following period			
4.00 5.00	Carryover of accumulated capital minimum payment level o	e instructions)	following period	0	15	