Heal th Financia	I Systems	MARION GENERAL	ΗΟΥΡΙ ΤΑΙ	Inlie	u of Form CMS-2552-10
	required by law (42 USC 1395g; 42 Cl				
payments made s	since the beginning of the cost repor	rting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 03-31-2022
	SPITAL HEALTH CARE COMPLEX COST REPO	ORT CERTIFICATION	Provider CCN: 15-0011	Period: From 07/01/2020	Worksheet S Parts I-III
AND SETTLEMENT	SUMMARY			To 06/30/2021	Date/Time Prepared:
					11/29/2021 7:49 am
PART I - COST R				D 1 11/00/0	
	1. [X] Electronically prepared cost 2. [] Manually prepared cost repor			Date: 11/29/2	021 Time: 7:49 am
	2. [] Manually prepared cost repor 3. [0] If this is an amended report		of times the provider r	asubmitted this co	ost report
	4. [F] Medicare Utilization. Enter	"F" for full or "L	" for low.		bat report
Contractor	5. [1] Cost Report Status 6. Date	Recei ved:		NPR Date:	
use only	(1) As Submitted 7. Contr	ractor No.		Contractor's Vendo	or Code: 4
	(2) Settled without Audit 8. [N	JINITIAI Report for	this Provider CCN 12.		nes reopened = 0-9.
	 (3) Settled with Audit (4) Reopened 				les l'eoperieu = 0-9.
	(5) Amended				
	· ·				
PART II - CERTI					
	ON OR FALSIFICATION OF ANY INFORMATI				
	ACTION, FINE AND/OR IMPRISONMENT UNE COURED THROUGH THE PAYMENT DIRECTLY (
	ACTION, FINES AND/OR IMPRISONMENT M		RICKDACK OK WERE OTHER	WISE TELEORE, CRIW	INAL, CIVIL AND
	ICATION BY CHIEF FINANCIAL OFFICER O		PROVI DER(S)		
	BY CERTIFY that I have read the above		• •	examined the acco	ompanyi ng
	pnically filed or manually submitted				
	es prepared by MARION GENERAL HOSPIT.				
	06/30/2021 and to the best of my kn				
	te and prepared from the books and r				
	as noted. I further certify that I care services, and that the service				
	nd regulations.		its cost report were pro		
	5				
	have read and agree with the above ignature on this certification state				
51			, , ,	or my original si	i gha tur e.
		(Si gned)		strator of Provid	er(s)
			officer of Admith		
			CFO		
			Title		
			(Dated when report	is electronical.	v signed)
			Date (Dated when report		y si gileu. j
			Date		
			T: +1 o V/////		

			litie	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	-107, 650	-4, 939	0	-537, 798	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-33, 987	0		-9, 600	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	-141, 637	-4, 939	0	-547, 398	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.

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	er CCN:		Period: From 07/01/ To 06/30/	2020 2021	u of For Workshe Part I Date/Ti 11/29/2	eet S-2 me Pre	pare
	1.00	2.00		3.00		2	4.00			
	Hospital and Hospital Health Care Co		_							
00	Street: 441 WABASH AVENUE	P0 Box:								1.
00	City: MARION	State: IN	Zip Cod			y: GRANT	-			2.
		Component Name	CCN	CBSA	Provi der	Date		nt Syst		
			Number	Number	- Туре	Certified		0, or		4
						5.00	V	XVIII	XIX	-
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
~~	Hospital and Hospital-Based Componer		450044	00045		07/04/40//	N		0	
00	Hospi tal	MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	0	3.
00	Subprovider - IPF		457044	00045	_	07 /01 /0005		Р		4.
00	Subprovider - IRF	MARION GENERAL HOSPITAL REHAB	15T011	99915	5	07/01/2005	N	P	0	5.
00	Subprovider - (Other)	REHAB					1			6.
00	,						1			7.
	Swing Beds - SNF						1			
00	Swing Beds - NF						1			8.
00	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospital-Based OLTC									11.
00	Hospi tal -Based HHA									12
00	1 3									13
00							l.			14
00							l.			15
00							l.			16
00	Hospital-Based (CMHC) I						Į			17
00	Renal Dialysis						Į			18
00	Other									19
						From:		То):	
						1.00		2.0	00	
00	Cost Reporting Period (mm/dd/yyyy)					07/01/20)20	06/30/	/2021	20.
00	Type of Control (see instructions)					2				21
					1.00	2.00		3. (00	
	Inpatient PPS Information									
00					Y	N				22
	disproportionate share hospital adju			2						
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		ndment							
	hospital?) In column 2, enter "Y" fo									
01	Did this hospital receive interim ur				N	Y				22
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N			ost						
	reporting period occurring on or aft									
02					N	N				22
	payments to be determined at cost re		structior	is)						
	Enter in column 1, "Y" for yes or "N					1				1
		i tor no, for the portio	n of the							1
	cost reporting period prior to Octob	er 1. Enter in column 2,	"Y" for							
		er 1. Enter in column 2,	"Y" for							
	cost reporting period prior to Octob or "N" for no, for the portion of the October 1.	er 1. Enter in column 2, he cost reporting period	"Y" for on or aft	er						
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04	cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in of for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	er 1. Enter in column 2, le cost reporting period ic reclassification from ds for delineating stati column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statist column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	"Y" for on or aft urban to stical ar "N" for r r 1. Ente e cost uctions) 9 beds (a 3, "Y" for urban to ical area "N" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" f and/or 25 s days, c in this c	er eas lo er s no s r s for for ar ar s or ar s or ar b ar ar b ar b ar ar b ar b ar b ar ar b ar ar ar ar ar ar ar ar ar ar	Ν			Ν		22

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT	MARION GENERAL HO	Provider CC	N· 15-0011	Peri od:	TH LIEU		et S-2	2552-10
				From 07/0	01/2020 30/2021	Part I Date/Ti 11/29/2	ime Pre	epared:
	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	ys Meo	ther di cai d days	
24.00 If this provider is an IPPS hospital, enter the	1.00 e 418	2.00	3.00	4.00	5.00	765	5.00 C	24.00
 24.00 If this provider is an IPPs hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 4, Medi HMO paid and eligible unpaid days in column 4, Medi HMO paid and eligible but unpaid days in column 	ate column ays in 11 -state caid		0	0		96		24.00
	1 5.			Urban/I	Rural S	Date of	- Geogr	
26.00 Enter your standard geographic classification ((not ware) status	at the beg	inning of t	1.	00 2	2.	00	26.00
 27.00 Enter your standard geographic classification (cost reporting period. Enter "1" for urban or " 27.00 Enter your standard geographic classification (reporting period. Enter in column 1, "1" for ur enter the effective date of the geographic recl 	2" for rural. (not wage) status ban or "2" for r	at the end ural. If ap	of the cos		2			27.00
35.00 If this is a sole community hospital (SCH), ent effect in the cost reporting period.			H status in		1			35.00
jerredt in the cost reporting perrod.				Begi n	ni ng:	Endi		
36.00 Enter applicable beginning and ending dates of	SCH status Subs	crint line	36 for numb		00 /2020	2.		36.00
of periods in excess of one and enter subsequer 37.00 If this is a Medicare dependent hospital (MDH),	nt dates.				0	007 30	/ 2021	37.00
 is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible accordance with FY 2016 OPPS final rule? Enter instructions) 								37. 01
38.00 If line 37 is 1, enter the beginning and ending greater than 1, subscript this line for the num enter subsequent dates.								38.00
					/N 00	Y/ 2.		-
39.00 Does this facility qualify for the inpatient hospitals in accordance with 42 CFR §412.101(b) 1 "Y" for yes or "N" for no. Does the facility accordance with 42 CFR 412.101(b)(2)(i), (ii), or "N" for no. (see instructions)	(2)(i), (ii), or meet the mileage or (iii)? Enter	(iii)? Ent requiremen in column 2	er in colum ts in "Y" for ye	me f in is	J	Ν	l	39.00
40.00 Is this hospital subject to the HAC program rec "N" for no in column 1, for discharges prior to no in column 2, for discharges on or after Octo					(Ν	1	40.00
no ni cordini 2, nor di scharges on or di ter octe			es or "N" f	or				
			es or "N" f	or	V 1.00	XVIII 2.00	XI X 3.00	
Prospective Payment System (PPS)-Capital	ober 1. (see inst	ructions)			1.00	2.00	3.00	45.00
45.00 With 42 CFR Section §412.320? (see instructions 46.00 Is this facility eligible for additional paymer	payment for disp	ructions) roportionat extraordina	e share in ry circumst	accordance ances				
Prospective Payment System (PPS)-Capital 15.00 Does this facility qualify and receive Capital with 42 CFR Section §412.320? (see instructions 16.00 Is this facility eligible for additional paymer pursuant to 42 CFR §412.348(f)? If yes, complet Pt. III. 17.00 Is this a new hospital under 42 CFR §412.300(b)	payment for disp payment for disp s) nt exception for ce Wkst. L, Pt. I PPS capital? E	ructions) roportionat extraordina II and Wkst nter "Y for	e share in ry circumst . L-1, Pt. yes or "N"	accordance ances I through for no.	1.00	0 2.00 N N N	3.00 N N N	46.00
Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital with 42 CFR Section §412.320? (see instructions f6.00 Is this facility eligible for additional paymer pursuant to 42 CFR §412.348(f)? If yes, complet Pt. III. 17.00 Is this a new hospital under 42 CFR §412.300(b) Is the facility electing full federal capital p Teaching Hospitals 56.00 Is this a hospital involved in training resider	payment for disp payment for disp b) t exception for ce Wkst. L, Pt. I PPS capital? E payment? Enter " hts in approved G	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y"	accordance ances I through for no. no.	1.00	0 2.00 N N	3.00 N N	46. 00 47. 00 48. 00
Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital with 42 CFR Section §412.320? (see instructions Is this facility eligible for additional paymer pursuant to 42 CFR §412.348(f)? If yes, complet Pt. III. Is this a new hospital under 42 CFR §412.300(b) Is the facility electing full federal capital p Teaching Hospitals	payment for disp payment for disp b) tt exception for ce Wkst. L, Pt. I p PPS capital? E payment? Enter " ints in approved G esponse to column GME programs in applicable CRs)	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this ear or penu	accordance ances I through for no. no. for yes o hospital I timate	1.00	0 2.00 N N N	3.00 N N N	46. 00 47. 00 48. 00
 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital with 42 CFR Section §412.320? (see instructions Is this facility eligible for additional paymer pursuant to 42 CFR §412.348(f)? If yes, complet Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) 48.00 Is the facility electing full federal capital p 56.00 Is this a hospital involved in training resider "N" for no in column 1. For column 2, if the rewas involved in training residents in approved year, and are you are impacted by CR 11642 (or Enter "Y" for yes; otherwise, enter "N" for no 	payment for disp payment for disp s) t exception for ce Wkst. L, Pt. I PPS capital? E eayment? Enter " this in approved G esponse to column GME programs in applicable CRs) in column 2. ting period duri 'Y" for yes or "N st month of this 2 is "Y", complet	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G ng which re " for no in cost report e Worksheet	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this ear or penu ME payment sidents in column 1. ing period?	accordance ances I through for no. no. for yes o hospital I timate reduction? approved If column ' Enter "Y	r N 1.00	0 2.00 N N N	3.00 N N N	46. 00 47. 00 48. 00 56. 00
 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital with 42 CFR Section §412.320? (see instructions ls this facility eligible for additional paymer pursuant to 42 CFR §412.348(f)? If yes, complet Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) 48.00 Is the facility electing full federal capital preaching Hospitals 56.00 Is this a hospital involved in training resider "N" for no in column 1. For column 2, if the rewas involved in training residents in approved year, and are you are impacted by CR 11642 (or Enter "Y" for yes; otherwise, enter "N" for no 57.00 If line 56 is yes, is this the first cost repor GME programs trained at this facility? Enter "is "Y" did residents start training in the first for yes or "N" for no in column 2. If column 2. 	payment for disp payment for disp b) t exception for wkst. L, Pt. I PPS capital? E payment? Enter " of PPS capital? E payment? Enter " this in approved G sponse to column GME programs in applicable CRs) in column 2. thing period duri Y" for yes or "N st month of this 2 is "Y", complet Pt. II, if appli reimbursement f	ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G ng which re " for no in cost report cable. or physicia	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this ear or penu ME payment sidents in column 1. ing period? E-4. If co	accordance ances I through for no. no. for yes o hospital Itimate reduction? approved If column ' Enter "Y Iumn 2 is	r N 1.00	0 2.00 N N N	3.00 N N N	45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00

	Financial Systems MARION AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		L HOSPITAL Provider C	F	In Lie Period: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	11/29/2021 7: Pass-Through Qual i fi cati on Cri teri on Code	
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	1.00 N	2.00	3.00	60.00
		Y/N	IME	Direct GME	IME	Direct GME	
41 00	Did your bestital receive FTE clats under ACA	1.00	2.00	3.00	4.00	5.00	41.00
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	
61. 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see				0.00		61. 20
	instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital	trai neo			iod for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	Teachi ram. (s	<u>see instructio</u>	. ,	your hospital	0.00	62.01
63.00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63.00
			¥	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	nprovi	der Settings	1.00 This base year	2.00 is your cost r	3.00 Teporting	
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>y</u> trair primar all nor non-pr columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00			64.00

		ATA Provider	Fr	eriod: .om 07/01/2020	Worksheet S-2 Part I	
			To	06/30/2021	Date/Time Pre 11/29/2021 7:	epared 49 am
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	позрітаі	4))	
-	1.00	2.00	3.00	4.00	5.00	1
5.00 Enter in column 1, if line 63			0.00	0.00	0. 000000) 65.0
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. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current Y	/ear FTE Residents i	n Nonprovider Settin				
beginning on or after July 1, 201 0.00 Enter in column 1 the number of u	10	•	0.00	•		
FTEs that trained in your hospita (column 1 divided by (column 1 +			Unweighted	Unweighted	Ratio (col. 3/	
			FTĔs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
00 Enter in column 1, the program	1.00	2.00	FTĔs Nonprovider Site 3.00	Hospi tal 4.00	(col. 3 + col. 4)) 5.00	_
7.00 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 FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	FTËs Nonprovider Site	Hospi tal	(col. 3 + col. 4)) 5.00	_
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	1.00	2.00	FTĔs Nonprovider Site 3.00	Hospi tal 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000	_
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)	25		FTĔs Nonprovi der Si te 3.00 0.00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	(col . 3 + col . 4)) 5.00 0.000000	D 67.1
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)	≥S rchiatric Facility (FTĔs Nonprovi der Si te 3.00 0.00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	(col . 3 + col . 4)) 5.00 0.000000	67.0
<pre>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)</pre>	≥S /chiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac ≷ 412.424 (d)(1)(iii ate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	Hospi tal 4.00 0.00 1.0 1.0 rovi der? N he most o. (see i ng o.	(col . 3 + col . 4)) 5.00 0.000000	70. (
<pre>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)</pre>	2S rchiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y / PPS nabilitation Facilit	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	Hospi tal 4.00 0.00 1.0 1.0 rovi der? N he most o. (see i ng o.	(col . 3 + col . 4)) 5.00 0.0000000 0.00000000000000000000	_

Health Financial Systems MAR	RION GENERAL	HOSPI TAL		In Lie	u of Form CMS	6-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	N DATA	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet S Part I Date/Time P 11/29/2021	repared:
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter 81.00 Is this a LTCH co-located within another hospital "Y" for yes and "N" for no. TEFRA Providers				g period? Enter	N N	80.00
85.00 Is this a new hospital under 42 CFR Section §413. 86.00 Did this facility establish a new Other subprovid	er (exclude				N	85.00 86.00
 §413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for 87.00 Is this hospital an extended neoplastic disease c 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for m 	are hospital	l classified	under section		N	87.00
	0.			V 1.00	XI X 2.00	-
Title V and XIX Services				1.00		
90.00 Does this facility have title V and/or XIX inpati- yes or "N" for no in the applicable column.	ent hospital	I services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XI. full or in part? Enter "Y" for yes or "N" for no				Ν	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII S instructions) Enter "Y" for yes or "N" for no in	NF beds (dua	al certificat			N	92.00
93.00 Does this facility operate an ICF/IID facility fo "Y" for yes or "N" for no in the applicable colum	r purposes (d XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y applicable column.	" for yes, a	and "N" for n	o in the	Ν	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage 96.00 Does title V or XIX reduce operating cost? Enter				0. 00 N	0. 00 N	95.00 96.00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage 98.00 Does title V or XIX follow Medicare (title XVIII) stepdown adjustments on Wkst. B, Pt. I, col. 25?	for the in	terns and res	idents post	0. 00 Y	0. 00 Y	97. 00 98. 00
 column 1 for title V, and in column 2 for title X 98.01 Does title V or XIX follow Medicare (title XVIII) C, Pt. I? Enter "Y" for yes or "N" for no in colu 	IX. for the rep	porting of ch	arges on Wkst	Y	Y	98. 01
<pre>title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y</pre>				Y	Y	98. 02
 98.03 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) reimbursed 101% of inpatient services cost? Enter 				N	N	98.03
<pre>for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) outpatient services cost? Enter "Y" for yes or "N</pre>				Ν	N	98.04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N"					Y	98. 05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) Pts. I through IV? Enter "Y" for yes or "N" for n column 2 for title XIX.</pre>				Y	Y	98.06
Rural Providers 105.00Does this hospital qualify as a CAH?				N		105.00
106.00 If this facility qualifies as a CAH, has it elect for outpatient services? (see instructions)	ed the all-i	inclusive met	hod of paymen			106.00
107.00 Column 1: If line 105 is Y, is this facility elig training programs? Enter "Y" for yes or "N" for n Column 2: If column 1 is Y and line 70 or line 7 approved medical education program in the CAH's e	o in column 5 is Y, do y	1. (see ins you train I&R	tructions) s in an	N		107.00
Enter "Y" for yes or "N" for no in column 2. (se 108.00 ls this a rural hospital qualifying for an except	e instructio ion to the (ons)		N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N"	for no.	Physi cal	Occupati ona	Speech	Respi ratory	/
109.00 If this hospital qualifies as a CAH or a cost pro	vidor aro	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? En for yes or "N" for no for each therapy.		N		N	11	109.00
					1.00	_
110.00 Did this hospital participate in the Rural Commun Demonstration) for the current cost reporting peri- complete Worksheet E, Part A, lines 200 through 2 applicable.	od? Enter "	Y" for yes or	"N" for no.	f yes,	N	110.00

Image: Marion General Hospital Hospital AND Hospital Health Care COMPLEX IDENTIFICATION DATA Provider Complex Provide	CN: 15-0011 P	In Lie Period:	u of Form CMS Worksheet S-	
IUSPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	F	rom 07/01/2020 o 06/30/2021	Part I	epared:
	I	1.00		
11.00 If this facility qualifies as a CAH, did it participate in the Frontier O Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0 115. 00
I16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
	Premi ums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:	1.00	2.00	3.00	0118.0
		1.00	2.00	_
18.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein.		1.00 N	2.00	118. 0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\ "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.	(" for yes or the Outpatient	Ν	N	119. 0 120. 0
21.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	es charged to	N		121. 0
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		N		122.0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the certi	fication date			126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certif	fication date			127. 0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	fication date			128. 0
 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 	cation date in			129. 0
20.00 lf this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	ti fi cati on			130. 0
31.00 If this is a Medicare certified intestinal transplant center, enter the c	certi fi cati on			131. 0
date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	fication date			132. 0
n n column i ann termination uate. If applicable, 11 COLUMN Z.				133. 0 134. 0
 33. 00 Removed and reserved 34. 00 If this is an organ procurement organization (0P0), enter the 0P0 number and termination date, if applicable, in column 2. All Providers 	in column 1			

OSPITAL AND HOSPITAL HEALTH CARE COMPLE		AL HOSPITAL Provider CC	N: 15-0011		i od: m 07/01/2020 06/30/2021	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 11/29/2021 7:	2 epared:
1.00	2.				3.00	<u> </u>	
If this facility is part of a chain home office and enter the home of				ie name	and address	or the	
41. 00 Name:	Contractor's Name:			actor's	s Number:		141.00
42.00 Street:	PO Box:						142.00
43.00 Ci ty:	State:		Zip C	ode:			143.00
						1.00	-
44.00 Are provider based physicians' cos	sts included in Worksheet	A?				Y	144.00
					1.00	2.00	
45.00 If costs for renal services are cl inpatient services only? Enter "Y"	aimed on Wkst. A, line /4	, are the costs	S TOP	c			145.00
no, does the dialysis facility ind							
period? Enter "Y" for yes or "N"			i opor tring				
46.00 Has the cost allocation methodolog					Ν		146. 00
Enter "Y" for yes or "N" for no in		15-2, chapter 4	10, §4020)	lf			
yes, enter the approval date (mm/o							
						1.00	1
47.00Was there a change in the statisti						N	147.00
48.00Was there a change in the order of				-		N	148.00
49.00Was there a change to the simplifi	ed cost finding method? E	2					149.00
		Part A 1.00	Part 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a prov	der that qualifies for a						
or charges? Enter "Y" for yes or '							
55.00Hospi tal		N	N		Ν	N	155. 0
56.00 Subprovider - IPF		N	N		N	N	156.0
57.00 Subprovider - IRF		N	N		N	N	157.0
58. OO SUBPROVI DER 59. OO SNF		N	N		Ν	N	158.00
60.00HOME HEALTH AGENCY		N	N N		N	N	160.00
61.00 CMHC			N		Ν	N	161.00
						1.00	
Multicampus 65.00 s this hospital part of a Multica	amous bospital that has or	e or more campi	ises in di	fferen	t CBSAs2	N	165.00
Enter "Y" for yes or "N" for no.				i i ci cii	C ODDAS:	1	105.00
· · ·	Name	County	State	Zip Co	ode CBSA	FTE/Campus	
	0	1.00	2.00	3.00	0 4.00	5.00	
66.00 If line 165 is yes, for each						0.00	166. 00
campus enter the name in column							
0 county in column 1 state in							
0, county in column 1, state in column 2, zip code in column 3,							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 2, zip code in column 3,							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						1 00	_
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	T) incentive in the Ameria	can Recovery and	d Rei nvest	ment A	ct	1.00	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in					ct	1.00 Y	167.0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	under §1886(n)? Enter " D5 is "Y") and is a meanim	'Y" for yes or " ngful user (line	'N" for no				
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter " D5 is "Y") and is a meanir HT assets (see instruction	'Y" for yes or " ngful user (line ons)	'N" for no e 167 is "	Y"), ei	nter the		168. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n	r under §1886(n)? Enter " D5 is "Y") and is a meanir HT assets (see instruction not a meaningful user, doe	Y" for yes or " ngful user (line ons) es this provider	'N" for no e 167 is " ⁻ qualify	Y"), en for a l	nter the		168. 0
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	' under §1886(n)? Enter " D5 is "Y") and is a meanir HT assets (see instruction not a meaningful user, doo PEnter "Y" for yes or "N"	Y" for yes or " ngful user (line ons) es this provider ' for no. (see i	'N" for no e 167 is " ⁻ qualify nstructio	Y"), en for a l ns)	nter the nardship	Y	168. 00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 if this provider is a CAH and is n exception under §413.70(a)(6)(ii)	under §1886(n)? Enter " 5 is "Y") and is a meanir 11 T assets (see instruction tot a meaningful user, doc 2 Enter "Y" for yes or "N" user (line 167 is "Y") and	Y" for yes or " ngful user (line ons) es this provider ' for no. (see i	'N" for no e 167 is " ⁻ qualify nstructio	Y"), en for a l ns)	nter the nardship	Y	168. 00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H escoption under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful u	under §1886(n)? Enter " 5 is "Y") and is a meanir 11 T assets (see instruction tot a meaningful user, doc 2 Enter "Y" for yes or "N" user (line 167 is "Y") and	Y" for yes or " ngful user (line ons) es this provider ' for no. (see i	'N" for no e 167 is " ⁻ qualify nstructio	Y"), en for a l ns)	nter the nardship), enter the Beginning	Y O. O(Endi ng	168. 00 168. 0 ⁻
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)' 69.00 If this provider is a meaningful u transition factor. (see instruction	under §1886(n)? Enter " D5 is "Y") and is a meanir HT assets (see instruction ta meaningful user, doo Enter "Y" for yes or "N" user (line 167 is "Y") and uns)	Y" for yes or " ngful user (line ons) es this provider for no. (see i d is not a CAH (N" for no e 167 is " - qualify nstructio (line 105	Y"), en for a l ns)	nter the nardship), enter the	Y 0. 00	168. 00 168. 01 0169. 00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) / 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H	under §1886(n)? Enter " D5 is "Y") and is a meanir HT assets (see instruction ta meaningful user, doo Enter "Y" for yes or "N" user (line 167 is "Y") and uns)	Y" for yes or " ngful user (line ons) es this provider for no. (see i d is not a CAH (N" for no e 167 is " - qualify nstructio (line 105	Y"), en for a l ns)	nter the nardship), enter the Beginning	Y O. O(Endi ng	168. 00 168. 01 0169. 00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)' 69.00 If this provider is a meaningful u transition factor. (see instruction	under §1886(n)? Enter " D5 is "Y") and is a meanir HT assets (see instruction ta meaningful user, doo Enter "Y" for yes or "N" user (line 167 is "Y") and uns)	Y" for yes or " ngful user (line ons) es this provider for no. (see i d is not a CAH (N" for no e 167 is " - qualify nstructio (line 105	Y"), en for a l ns)	nter the nardship), enter the Beginning	Y O. O(Endi ng	168. 00 168. 0 ⁻ 0169. 00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) / 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H	under §1886(n)? Enter " D5 is "Y") and is a meanir HT assets (see instruction ta meaningful user, doo Enter "Y" for yes or "N" user (line 167 is "Y") and uns)	Y" for yes or " ngful user (line ons) es this provider for no. (see i d is not a CAH (N" for no e 167 is " - qualify nstructio (line 105	Y"), en for a l ns)	nter the nardship), enter the Beginning	Y O. O(Endi ng	168. 00 168. 01 0169. 00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this provider	under §1886(n)? Enter " 5 is "Y") and is a meanin 11 assets (see instruction to a meaningful user, doe 2 Enter "Y" for yes or "N" user (line 167 is "Y") and peginning date and ending vider have any days for in	Y" for yes or " ngful user (line ons) es this provider for no. (see i d is not a CAH (date for the re	N" for no e 167 is " r qualify nstructio line 105 eporting led in	Y"), er for a l ns) i s "N";	nter the nardship), enter the Beginning 1.00	Y 0. 00 Endi ng 2. 00 2. 00	167. 00 168. 00 168. 01 0 169. 00 170. 00
col umn 2, zip code in col umn 3, CBSA in col umn 4, FTE/Campus in col umn 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in col umns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	- under §1886(n)? Enter " 15 is "Y") and is a meanin 11 assets (see instruction to a meaningful user, dow 2 Enter "Y" for yes or "N" user (line 167 is "Y") and to and and ending peginning date and ending rider have any days for in reported on Wkst. S-3, Pt.	Y" for yes or " ngful user (line ons) es this provider for no. (see i d is not a CAH (date for the re ndividuals enrol l, line 2, col	N" for no e 167 is " qualify nstructio (line 105 eporting led in . 6? Ente	Y"), er for a l ns) i s "N";	nter the nardship), enter the Beginning 1.00 1.00	Y 0. 00 Endi ng 2. 00 2. 00	168. 00 168. 0 0169. 00 170. 00

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Pro 11/29/2021 7	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponsos Ente	1.00	2.00	
	mm/dd/yyyy format.		Sponses. Ente		iic iii	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.0
	Treporting periods in yes, enter the date of the enange in e	01 01111 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3.0
			Y/N	Туре	Date	
	Financial Data and Danasta		1.00	2.00	3.00	
. 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. Are the cost report total expenses and total revenues diffe	or Compiled, ilable in	Y	A		4. C
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	5 N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	N N		7. 0 8. 0
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	0	cal education	Ν		9. (
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		the current	Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	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			ost reporting	Y N	12. 0 13. 0
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I1	fyes, see ins	structions.	Ν	14. (
5.00	Did total beds available change from the prior cost reporti		yes, see inst rt A	tructions. Par	Y t B	15. (
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.0
7. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	10/06/2021	Υ	10/06/2021	17. (
8. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. (
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
9. 00	Report data for corrections of other PS&R Report	Ν		Ν		19. (

	Financial Systems MARION GENER AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0011	Peri od: From 07/01/2020 To 06/30/2021	u of Form CM Worksheet S Part II Date/Time P 11/29/2021	-2 repared:
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1. 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 Capital Related Cost	EPT CHILDRENS I	HOSPI TALS)			
2. 00 3. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			ing the cost		22. 00 23. 00
4.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter-		24.00			
5.00	If yes, see instructions Have there been new capitalized leases entered into during instructions.		25.00			
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost report	ing period? I	f yes, see		26.00
7.00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit		27.00
8. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into du	ring the cost	reporting		28.00
9. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service R	eserve Fund)		29.00
0. 00	Has existing debt been replaced prior to its scheduled matrinstructions.		debt? If yes	, see		30.00
1. 00	Has debt been recalled before scheduled maturity without is instructions. Purchased Services	ssuance of new	debt? If yes	, see		31.00
2.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instri	rvices furnish uctions.	ed through co	ntractual		32.00
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertaini	ng to competi	tive bidding? If		33.00
4.00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement wit	h provider-ba	ised physi ci ans?		34.00
5.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1.00	2.00	_
	Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	renared by the	home office?	,		36.00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of					38.00
	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to othe	d of the home	offi ce.			39.00
0. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40.00
		1	. 00	2.	00	_
	Cost Report Preparer Contact Information			2.		
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41.00
	respectively. Enter the employer/company name of the cost report	BLUE AND CO.,	LLC			42.00
2.00	preparer.					

Heal th	Financial Systems MARION GENI	ERAL HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10		
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0011	Period:	Worksheet S-2		
			From 07/01/2020 To 06/30/2021		pared: 49 am	
		3.00				
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	MANAGER			41.00	
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
42.00	Enter the employer/company name of the cost report				42.00	
	preparer.					
43.00	Enter the telephone number and email address of the cost				43.00	
	report preparer in columns 1 and 2, respectively.					

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	MARION GENERA	Provi der CO	CN· 15-0011	Peri od:	u of Form CMS-2 Worksheet S-3	
1105111	AL AND HOST THE HEALTH OAKE COMPLEX STATISTIC			5N. 13 0011	From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre 11/29/2021 7:	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	89	32, 48	85 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed SM					0	6.00
7.00	Total Adults and Peds. (exclude observation		89	32, 4	35 0.00	0	
	beds) (see instructions)		0,	02/ 11	0.00	Ũ	
8.00	INTENSIVE CARE UNIT	31.00	21	7,6	65 0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		110	40, 1	50 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40. 00	0		0	0	16.00
17.00	SUBPROVIDER - IRF	41.00	18			0	17.00
18.00	SUBPROVIDER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	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	30.00					24.00
24.10 25.00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24.10
26.00	RURAL HEALTH CLINIC						25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)	07.00	128			0	27.00
28.00	Observation Bed Days		120			0	•
29.00	Ambul ance Trips					Ū	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room		0				32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	1	Period: From 07/01/2020 To 06/30/2021		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	4, 576 3, 689	418 3, 869 0	11, 47.	2		1.00 2.00 3.00
4.00	HMO I RF Subprovi der	311	96				4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF	0	90 0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4, 576	418	11, 47	-		7.00
8.00 9.00 10.00 11.00 12.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	955	0	3, 59	7		8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	5, 531 0	0 418 0	1, 57 16, 63		751.50	13.00 14.00 15.00
16.00	SUBPROVIDER - IPF	0	0		0 0.00	0.00	16.00
17.00	SUBPROVIDER – IRF	2, 109	11	2, 85	8 0.00	16.60	17.00
18.00 19.00 20.00 21.00 22.00 23.00	SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)		0		0 0.00	0.00	19.00 20.00 21.00 22.00 23.00
24.00 24.10 25.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC			14	9		24.00 24.10 25.00
26.00 26.25 27.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0	0		0 0.00 0.00 0.00		27.00
28.00 29.00 30.00 31.00 32.00 32.01	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	1, 177 0	817 0				28.00 29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0 0					33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Prep 11/29/2021 7:4	pared:
		Full Time Equivalents	Di s		charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 00\\ 26.\ 25\\ 07\\ 26.\ 00\\ 2$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00 0.00 0.00 0.00 0.00	0 0 0 0 0	1, 4	09 962 0 12	4, 129 4, 129 0 273 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.00 27.00 20.0
27.00 28.00 29.00 30.00 31.00 32.00 32.01	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00					27.00 28.00 29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0		33. 00 33. 0 ⁻

PI T.	Financial Systems AL WAGE INDEX INFORMATION		MARION GENER	Provider CC	F	veriod: rom 07/01/2020 o 06/30/2021		pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	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							
0	Total salaries (see	200. 00	55, 113, 674	21, 202, 275	76, 315, 949	2, 135, 524. 30	35.74	1.
0	instructions) Non-physician anesthetist Part		C	0	C	0.00	0.00	2.
0	A		C	0		0.00	0.00	Z.
0	Non-physician anesthetist Part		C	0	C	0.00	0.00	3.
0	B Physician-Part A -		589, 469	0	589, 469	2, 965. 59	198. 77	4
	Admi ni strati ve		,	_				
1 0	Physicians - Part A - Teaching		C 4, 555, 299	0	4 555 200	0.00		
0	Physician and Non Physician-Part B		4, 555, 299	0	4, 555, 299	24, 030. 00	189. 57	5
0	Non-physician-Part B for		C	0	C	0.00	0.00	6
	hospital-based RHC and FQHC services							
0	Interns & residents (in an	21.00	C	0	C	0.00	0.00	7
	approved program)							_
1	Contracted interns and residents (in an approved		C	0 0	C	0.00	0.00	7
	programs)							
0	Home office and/or related		C	0	C	0.00	0.00	8
0	organization personnel SNF	44.00	C	0	C	0.00	0.00	9
00	Excluded area salaries (see		9, 626, 995	13, 815, 885	23, 442, 880			
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract labor: Direct Patient		1, 644, 995	0	1, 644, 995	22, 134. 00	74. 32	111
	Care							
00	Contract labor: Top level management and other		C	0	C	0.00	0.00	12
	management and administrative							
~~	servi ces				447.450	(10, 00	100 51	
00	Contract Labor: Physician-Part A - Administrative		117, 150	0	117, 150	649.00	180. 51	
00	Home office and/or related		C	0	C	0.00	0.00	14
	organization salaries and wage-related costs							
01	Home office salaries		C	0	C	0.00	0.00	14
02	Related organization salaries		C	0	C	0.00		
00	Home office: Physician Part A - Administrative		C	0	L C	0.00	0.00	15
00	Home office and Contract		C	0	C	0.00	0.00	16
01	Physicians Part A - Teaching		~			0.00	0.00	1.
01	Home office Physicians Part A - Teaching		Ĺ	0		0.00	0.00	
02	Home office contract		C	0	C	0.00	0.00	16
	Physicians Part A - Teaching WAGE-RELATED COSTS							
	Wage-related costs (core) (see		13, 816, 316	0	13, 816, 316			17
00	instructions)							10
00	Wage-related costs (other) (see instructions)							18
00	Excluded areas		5, 850, 415	0	5, 850, 415			19
00	Non-physician anesthetist Part		C	0	C			20
00	A Non-physician anesthetist Part		C	0	c			21
	В							
00	Physician Part A - Administrative		76, 237	0	76, 237			22
	Physician Part A - Teaching		C	0	C)		22
	Physician Part B		599, 123	0	599, 123			23
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		(24 25
	approved program)							
50	Home office wage-related		C	0	C			25
51	(core) Related organization		C	0	C			25
	wage-related (core)							
52	Home office: Physician Part A - Administrative -		C	0	C			25
	wage-related (core)							

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-10			
	AL WAGE INDEX INFORMATION			Provider CO	CN: 15-0011	Period: From 07/01/2020 To 06/30/2021			
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly		
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from Wkst.	(col.2 ± col	. Salaries in	col. 5)		
				A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
25.53	Home office: Physicians Part A		0	0		0		25.53	
	- Teaching - wage-related								
	(core)								
	OVERHEAD COSTS - DIRECT SALARII								
26.00	Employee Benefits Department	4.00	1 - 1						
27.00	Administrative & General	5.00			15, 180, 73	419, 453. 60	36. 19	27.00	
28.00	Administrative & General under		1, 591, 632	0	1, 591, 63	15, 848. 47	100. 43	28.00	
	contract (see inst.)								
29.00	Maintenance & Repairs	6.00		0		0 0.00		29.00	
30.00	Operation of Plant	7.00	789, 094	0	789, 09	35, 863. 50	22.00	30.00	
31.00	Laundry & Linen Service	8.00	0	0		0 0.00	0.00	31.00	
32.00	Housekeepi ng	9.00	0	0		0 0.00		32.00	
33.00	Housekeeping under contract		1, 350, 750	0	1, 350, 75	100, 979. 00	13.38	33.00	
	(see instructions)								
34.00	Dietary	10.00	19, 403	0	19, 40			34.00	
35.00	Dietary under contract (see		350, 077	0	350, 07	22, 678. 52	15.44	35.00	
	instructions)								
36.00	Cafeteri a	11.00		0		0 0.00		36.00	
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00	
38.00	Nursing Administration	13.00	1, 613, 149	-543, 921	1, 069, 22	27, 536. 10	38.83	38.00	
39.00	Central Services and Supply	14.00	140, 717	0	140, 71	7 7, 484. 50	18.80	39.00	
40.00	Pharmacy	15.00	2, 658, 294	-7, 894	2, 650, 40	65, 617. 00	40.39	40.00	
41.00	Medical Records & Medical	16.00	0	0		0 0.00	0.00	41.00	
	Records Library								
42.00	Social Service	17.00	0	0		0 0.00	0.00	42.00	
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00	

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION						Period: Worksheet S-3 From 07/01/2020 Part III To 06/30/2021 Date/Time Prepared: 11/29/2021 7:49 am			
		Worksheet A		Recl assi fi cati			Average Hourly		
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_			
1.00	Net salaries (see		53, 850, 834	21, 202, 275	75, 053, 10	9 2, 251, 000. 29	33. 34	1.00	
	instructions)								
2.00	Excluded area salaries (see instructions)		9, 626, 995	13, 815, 885	23, 442, 88	608, 770. 40	38. 51	2.00	
3.00	Subtotal salaries (line 1		44, 223, 839	7, 386, 390	51, 610, 22	9 1, 642, 229. 89	31.43	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		1, 762, 145	0	1, 762, 14	5 22, 783. 00	77.34	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		13, 892, 553	0	13, 892, 55	3 0.00	26. 92	5.00	
(00	(see inst.)		50 070 507	7 00/ 000	(7.0(4.00)	1 / / 5 010 00	10.10	(00	
6.00	Total (sum of lines 3 thru 5)		59, 878, 537						
7.00	Total overhead cost (see		21, 782, 728	2, 538, 837	24, 321, 56	5 726, 046. 29	33.50	7.00	
	instructions)								

ealth Financial Systems	MARION GE	ENERAL HOSPITAL	-		u of Form CMS-2	
OSPITAL WAGE RELATED COSTS		Provider CCN	l: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Pre 11/29/2021 7:4	parec
					Amount Reported	
					1.00	
PART IV - WAGE RELATED COST	6					
Part A - Core List						
RETI REMENT COST						
.00 401K Employer Contributions					1, 499, 370	
. 00 Tax Shel tered Annui ty (TSA)					0	
	t Plan Cost (see instruction	is)			0	3.
.00 Qualified Defined Benefit P					2, 000, 000	4.0
.00 PLAN ADMINISTRATIVE COSTS (1 401K/TSA PLan Administratio	3	11)			0	5.0
. 00 Legal /Accounting/Management					0 2, 499, 055	5. 6.
. 00 Employee Managed Care Progr					2, 499, 033	7.
HEALTH AND INSURANCE COST	an Administration rees				0	/. '
. 00 Heal th Insurance (Purchased	or Self Eunded)				0	8.0
	ed without a Third Party Adm	inistrator)			0	8.
	ed with a Third Party Admini				8, 328, 511	
. 03 Heal th Insurance (Purchased					0,020,011	
. 00 Prescription Drug Plan					0	
0.00 Dental, Hearing and Vision	PI an				0	10.
1.00 Life Insurance (If employee					51, 877	11.
2.00 Accident Insurance (If empl	oyee is owner or beneficiary	')			0	12.0
3.00 Disability Insurance (If em	ployee is owner or beneficia	iry)			373, 639	13.
4.00 Long-Term Care Insurance (I	f employee is owner or benef	ïciary)			0	14.
5.00 'Workers' Compensation Insu					376, 450	15.0
6.00 Retirement Health Care Cost	(Only current year, not the	extraordi nary accr	ual require	ed by FASB 106.	0	16.0
Non cumulative portion)						
TAXES					1.0(0.(04	47
7.00 FICA-Employers Portion Only					4, 960, 694	
8.00 Medicare Taxes - Employers 9.00 Unemployment Insurance	Portion Uniy				0	
0.00 State or Federal Unemployme	at Taxoc				57, 014 0	
OTHER	III Taxes				0	20.
1.00 Executive Deferred Compensa instructions))	tion (Other Than Retirement	Cost Reported on li	nes 1 throu	igh 4 above. (see	0	21.0
2.00 Day Care Cost and Allowance	S				0	22.
3.00 Tuition Reimbursement	2				195, 479	
4.00 Total Wage Related cost (Su	m of lines 1 -23)				20, 342, 089	
Part B - Other than Core Re					20, 342, 007	27.
5. 00 OTHER WAGE RELATED COSTS (S						25.0

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0011	Peri od:		Worksheet S-3	
					/01/2020		
				To 06,	/30/2021	Date/Time Pre 11/29/2021 7:	
	Cost Center Description			Contra	ct Labor		
	obst center bescription				. 00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identii	fication:					
1.00	Total facility's contract labor and benefit	cost		1	, 644, 995	20, 342, 089	1.00
2.00	Hospi tal			1	, 644, 995	20, 342, 089	2.00
3.00	Subprovider - IPF				0	0	3.00
4.00	Subprovider - IRF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF						8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA						11.00
12.00	Separately Certified ASC						12.00
13.00	Hospital-Based Hospice						13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis						17.00
18.00	Other				0	0	18.00

Heal th	Financial Systems MARION GENERAL HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	l: 15-0011	Peri od:	Worksheet S-1	0
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line	e 202 columr	8)	0. 247288	1.00
	Medicaid (see instructions for each line)	3		,		
2.00	Net revenue from Medicaid				3, 335, 294	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement.		from Medica	i d?	N	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	om Medicaid			0 87, 628, 303	5.00 6.00
8.00 7.00	Medicaid cost (line 1 times line 6)				21, 669, 428	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus	s sum of lir	es 2 and 5 [.] if	18, 334, 134	8.00
0100	< zero then enter zero)				10,001,101	0.00
	Children's Health Insurance Program (CHIP) (see instructions for	r each line))			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			c	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (enter zero)	line 11 minu	us line 9; i	f < zero then	0	12.00
	Other state or local government indigent care program (see insti	ructions for	each line)			
13.00	Net revenue from state or local indigent care program (Not inclu			')	0	13.00
14.00	Charges for patients covered under state or local indigent care				0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for state or local ind	igent care p	orogram (lir	e 15 minus line	0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHII	P and state	/local indic	ont caro progra		
	instructions for each line)			ent care progra	115 (366	
17.00	Private grants, donations, or endowment income restricted to fu	nding charit	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of h				0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent ca	are programs	(sum of lines	18, 334, 134	19.00
			Uni nsured	Insured	Total (col. 1	
		_	patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20, 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	: 1 : + 1	11, 758, 94	2 3, 180, 287	14, 939, 229	20.00
20.00	(see instructions)	iiity	11, 758, 92	3, 180, 287	14, 939, 229	20.00
21.00	Cost of patients approved for charity care and uninsured discou	nts (see	2,907,84	5 3, 180, 287	6, 088, 132	21.00
211.00	instructions)		21,10110	0,100,20,	0,000,102	200
22.00	Payments received from patients for amounts previously written	off as		0 229	229	22.00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)		2, 907, 84	3, 180, 058	6, 087, 903	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	t days beyon	ad a length	of stay limit	N 1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent care		la a rengen	or stay rimit	14	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the		care program	's length of	0	25.00
0/ 00	stay limit				0 404 504	0/ 00
26.00 27.00	Total bad debt expense for the entire hospital complex (see ins		(ctions)		8, 136, 534 425, 122	
27.00	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (s				654, 033	
27.01	Non-Medicare bad debt expense (see instructions)	ee matructi	013)		7, 482, 501	
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see ir	nstructions)		2, 079, 244	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				8, 167, 147	
	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			26, 501, 281	

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	- EXPENSES	Provider CO		eriod: rom 07/01/2020	Worksheet A	
				Т	o 06/30/2021	Date/Time Pre 11/29/2021 7:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS				1		
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	1 102 (10	12, 926, 858			11, 712, 051	
. 00 . 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL	1, 102, 610 12, 167, 002	18, 118, 860 30, 427, 021	19, 221, 470 42, 594, 023		19, 298, 393 42, 926, 782	
. 00	00600 MAI NTENANCE & REPAI RS	0	0, 427, 021	42, 374, 023	0 0	42, 720, 702	
. 01	00601 CAFETERI A	О	0	0	1, 624, 857	1, 624, 857	6.01
. 02		0	0	0	0	0	
. 00 . 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	789, 094	4, 656, 504 0	5, 445, 598	367, 039 320, 907	5, 812, 637 320, 907	7.00
. 00	00900 HOUSEKEEPING	0	3, 013, 379	3, 013, 379		2, 701, 557	9.00
0.00	01000 DI ETARY	19, 403	2, 282, 395	2, 301, 798		646, 600	
3.00	01300 NURSI NG ADMI NI STRATI ON	1, 613, 149	75, 899	1, 689, 048		1, 145, 127	
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	140, 717 2, 658, 294	354, 085 12, 942, 704	494, 802 15, 600, 998		494, 802 3, 613, 886	
5.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,030,274	12, 742, 704	13, 000, 770	11,707,112	3, 013, 000	15.00
0. 00	03000 ADULTS & PEDI ATRI CS	6, 542, 938	1, 481, 454			6, 870, 756	30.00
1.00	03100 I NTENSI VE CARE UNI T	1, 921, 443	469, 090	2, 390, 533	-76, 923	2, 313, 610	
0.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0 1, 045, 084	0 809, 818	1, 854, 902	0 0	0 1, 854, 902	
2.00	04200 SUBPROVI DER	0	0	0		0	
3.00	04300 NURSERY	0	0	0	1, 462, 633	1, 462, 633	43.00
0 00	ANCI LLARY SERVICE COST CENTERS	2 020 170	(551 000	0 501 007	207.404	0.070.401	1 50 00
0.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	3, 039, 178	6, 551, 829 0	9, 591, 007	287, 484	9, 878, 491 0	50.00 51.00
4.00	05400 RADI OLOGY-DI AGNOSTI C	3, 161, 484	2, 758, 123	5, 919, 607	-1, 017, 532	4, 902, 075	
7.00	05700 CT SCAN	О	0	0	965, 392	965, 392	
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		482, 652	482, 652	
9.00 0.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	638, 196 2, 232, 964	1, 641, 862 5, 965, 057	2, 280, 058 8, 198, 021		2, 312, 842 8, 210, 407	
0.01	06001 ONCOLOGY	1, 015, 079	678, 821	1, 693, 900		1, 693, 900	
0. 02	06002 RADI ATI ON ONCOLOGY	о	0	0	0	0	
4.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0	0	
5.00 6.00	06600 PHYSI CAL THERAPY	1, 346, 001 2, 022, 437	887, 981 153, 593	2, 233, 982 2, 176, 030		2, 244, 627 2, 204, 999	65.00 66.00
9.00	06900 ELECTROCARDI OLOGY	778, 409	196, 861	975, 270		1, 064, 882	
9. 01	06901 CARDI AC REHAB	142, 467	34, 875	177, 342	31, 387	208, 729	
1.00 2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	-		
	OUTPATIENT SERVICE COST CENTERS				1		
0.00		300, 367	729, 734				
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	3, 855, 447	6, 870, 054	10, 725, 501	-60, 851	10, 664, 650	91.00
2.01	09201 OBSERVATION BEDS (DISTINCT PART)	о	0	0	0	0	
	OTHER REIMBURSABLE COST CENTERS						
5.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 027, 863	201, 305	1, 229, 168	30, 769	1, 259, 937	95.00
13 00	D11300 INTEREST EXPENSE		0	0	0	0	113.00
18.00		47, 559, 626	114, 228, 162			161, 966, 931	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 647	5, 647	21, 538	27, 185	
	19200 PHYSICIANS' PRIVATE OFFICES	0 108, 115	0 919, 621	1, 027, 736	-394, 173	0 633, 563	192.00 192.01
	19202 VI SI TOR MEALS	0	0	0	0		192.02
92.03	19203 GREAT BEGI NNI NGS/MATERNAL	78, 412	2, 897	81, 309	8, 432	89, 741	192.03
		0	1 500 124	0 1, 500, 134	0 1 001 174		192.04
	19205 OWNED PROPERTIES 19206 UROLOGY	341, 938	1, 500, 134 936, 657	1, 278, 595		418, 960 1, 320, 478	
	19207 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.07
	3 19211 PARI SH NURSI NG	54, 662	13, 065	67, 727	8, 106	75, 833	
	19212 BIOTERRORI SM GRANT	0	0	0	0		192.09
	D 19214 BREAST PUMPS I 19208 MGH EMERGENCY PHYSI CLANS	0	0	0	0		192.10 192.11
92.12	19209 LUNG CENTER	118, 931	677, 906	796, 837		826, 194	192.12
	19213 MGH EXPRESS	553, 530	712, 811	1, 266, 341		1, 306, 878	
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	1, 338, 512 417, 504	709, 697 1, 433, 760	2, 048, 209		2, 092, 817	
	19215 MGH MARTON SURGEONS 19216 MGH MGH MED ONC	417, 504 105	1, 433, 760	1, 851, 264 1, 375, 169		1, 926, 835 1, 375, 169	
	19217 MGH FMC SOUTH	701, 252	1, 664, 429			2, 726, 671	
	3 19218 MGH FAI RM MED ASSOC	136, 791	278, 918	415, 709	32, 491	448, 200	
U) 10	9 19219 MGH FMC MARION	372, 564	834, 503	1, 207, 067	64, 856	1, 271, 923	192.19

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Peri od:	Worksheet A	
				From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/29/2021 7:	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	
oust center beschiption	Sararres	other	+ col. 2)	ons (See A-6)	Trial Balance	
			,		(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
193.01 19301 MGH FMC NORTHWOOD	316, 812	839, 318	1, 156, 13	0 14, 144	1, 170, 274	193.01
193.02 19302 MGH FMC GAS CITY	287, 536	693, 674	981, 210	80, 729	1, 061, 939	193. 02
193. 03 19303 MGH HOSPI TALI STS	102, 974	3, 058, 176	3, 161, 150	0 0	3, 161, 150	193.03
193.04 19304 MGH MAR FAM PRACT	1,057,572	2, 478, 490	3, 536, 06	2 50, 893	3, 586, 955	193.04
193.05 19305 MGH FMC SWAYZEE	76, 728	162, 982	239, 710	26, 755	266, 465	193.05
193.06 19306 MGH PEDIATRIC CTR	186, 774	542, 850	729, 62	4 60, 338	789, 962	193.06
193.07 19307 MGH SPECIALTY PHYS	57, 824	253, 934	311, 75	8 14, 497	326, 255	193.07
193.08 19308 MGH FMC CONVERSE	102, 808	244, 897	347, 70	5 307	348, 012	193.08
193.09 19309 MGH UPLAND HEALTH	55, 230	29, 421	84, 65	1 1, 629	86, 280	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0	0	193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0	(0 0	0	193. 11
193. 12 19312 OB/GYN	526, 837	2, 358, 264	2, 885, 10	1 73, 421	2, 958, 522	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0	193. 15
193.16 19316 MGH NEONATOLOGY	0	888, 000	888, 00	0 0	888, 000	193. 16
193.18 19318 MGH WOUND CARE	0	25, 455	25, 45	5 0	25, 455	193. 18
194.0007963 HEART FAILURE CLINIC	0	59, 037		7 0	59, 037	194.00
194.0107950 MOW	0	0		0 0	0	194.01
194.0207951 MENTAL HEALTH	0	0	(0 0	0	194.02
194. 03 07952 ADVERTI SI NG	0	0	(251, 419	251, 419	194.03
194.04 07953 MGH WORK SOLUTIONS	289, 655	575, 426	865, 08	1 3, 302	868, 383	194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	153	812	96	5 0	965	194.05
194.06079550PIOID IMPL GRANT	60, 565	227, 546	288, 11	1 7, 023	295, 134	194.06
194.0707956 ASTHMA GRANT	2, 697	476	3, 17	3 0	3, 173	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	0	194. 11
194. 12 07961 GAS CI TY	0	0	(0 0	0	194. 12
194. 13 07969 LYONS	0	0	(0 0	0	194. 13
194.1407964 WABASH	0	0	(0 0	0	194.14
194.1507965 TOBACCO GRANT	42, 338	7, 365	49, 70	3 4, 443	54, 146	194. 15
194.16 07966 HRSA NETWORK DEV PLANNING	0	0	(0 0	0	194. 16
194. 17 07967 HRSA OPI OLD PLANNI NG	0	0	(0 0	0	194. 17
194.1807962 ECHO GRANT	3, 153	48, 842	51, 99	5 0	51, 995	194. 18
194. 19 07968 RURAL QI GRANT	40, 459	128, 883	169, 34	2 0	169, 342	194. 19
194.2007970 MGH DIABETES GRANT	0	0	(0 0	0	194. 20
194.2107971 MGH MGH ORTHO	0	0	(0 0	0	194. 21
194.2207972 MGH BELLA BLDG	0	0	(0 0	0	194. 22
194. 23 07973 DI ABETES GRANT	0	4, 026	4, 02	6 0	4, 026	194. 23
194.24 07974 MGH NORTHWOOD BLDG	0	0	(0 C	0	194. 24
194.2507975 MGH MGH ORTHO	121, 617	331, 360	452, 97	7 -21, 065	431, 912	
200.00 TOTAL (SUM OF LINES 118 through 199)	55, 113, 674	138, 252, 505	193, 366, 17	9 0	193, 366, 179	200. 00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARION GENER	AL HOSPITAL Provider CCN:		eu of Form CMS-2552-10 Worksheet A
				From 07/01/2020 To 06/30/2021) 1 Date/Time Prepared:
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		11/29/2021 7:49 am
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-18, 183			1.00
4.00 5.00		-3, 275, 677			4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	- 16, 709, 888			5. 00 6. 00
6.01	00601 CAFETERIA	-4, 477	-		6. 01
6.02	00602 CAFETERI A	0	0		6. 02
7.00	00700 OPERATION OF PLANT	-172, 972			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-3, 483			8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DI ETARY	-62			9.00 10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-405			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-366			14.00
	01500 PHARMACY	-23, 573			15.00
	INPATIENT ROUTINE SERVICE COST CENTERS		1		
30.00	03000 ADULTS & PEDIATRICS	-9,777			30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	-956			31.00 40.00
40.00	04100 SUBPROVIDER - IRF	-70, 111	-		40.00
42.00	04200 SUBPROVI DER	0			42.00
43.00	04300 NURSERY	0	1, 462, 633		43.00
	ANCI LLARY SERVICE COST CENTERS				
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	-1, 461, 717	8, 416, 774		50.00 51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-184, 579	4, 717, 496		54.00
57.00	05700 CT SCAN	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	-169, 265			59.00
60.00		-114, 206			60.00
60. 01 60. 02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	-4, 637			60. 01 60. 02
64. 00	06400 I NTRAVENOUS THERAPY				64.00
65.00	06500 RESPI RATORY THERAPY	-1, 314	-		65.00
66.00	06600 PHYSI CAL THERAPY	-147	2, 204, 852		66.00
69.00	06900 ELECTROCARDI OLOGY	-53, 950			69.00
69.01	06901 CARDI AC REHAB	-6			69.01
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				71.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-1, 226			90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-5, 099, 169	5, 565, 481		91.00 92.00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVI CES	-58, 789	1, 201, 148		95.00
112 00	SPECIAL PURPOSE COST CENTERS				112.00
113.00		0 -27, 438, 935			113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	27,430,733	134,327,770		110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27, 185		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
	19201 PACT REV PHYSICIANS 19202 VISITOR MEALS	0			192. 01 192. 02
	19202 VISITOR MEALS		°		192.02
	19204 LI FELI NE	0			192.04
	19205 OWNED PROPERTIES	0	418, 960		192.05
	19206 UROLOGY	-60, 686			192.06
	19207 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.07
	19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT	0	75, 833 0		192. 08 192. 09
	19214 BREAST PUMPS		0		192.10
192.11	19208 MGH EMERGENCY PHYSICIANS	0	0		192. 11
	19209 LUNG CENTER	-49, 887			192.12
	19213 MGH EXPRESS	0	1,000,070		192.13
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	-66, 167 -117, 008			192. 14 192. 15
	19216 MGH MGH MED ONC	-117,008			192.15
	19217 MGH FMC SOUTH	-350, 410			192.17
192.18	19218 MGH FAIRM MED ASSOC	-28, 067	420, 133		192. 18
	19219 MGH FMC MARION	-94, 562			192.19
	19300 NONPALD WORKERS 19301 MGH FMC NORTHWOOD	0 -28, 176	-		193. 00 193. 01
	19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY	-149, 966			193. 01
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	,			

193. 03 193. 04 193. 04 193. 04 193. 05 193. 05 193. 05 193. 05 193. 06 193. 06 193. 06 193. 07 193. 07 193. 07 193. 08 193. 193. 193. 193. 193. 193. 193. 193.	Adjustments	240, 113 720, 784	: 15-0011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet A Date/Time Prepared 11/29/2021 7: 49 at 193. 193. 193.
193. 03 193. 04 193. 04 193. 04 193. 05 193. 05 193. 05 193. 05 193. 06 193. 06 193. 06 193. 07 193. 07 193. 07 193. 08 193. 193. 193. 193. 193. 193. 193. 193.	<u>(See A-8)</u> <u>6.00</u> 0 -108, 358 -26, 352 -69, 178 -25, 556 0	For Allocation 7.00 3,161,150 3,478,597 240,113 720,784 300,699			11/29/2021 7: 49 at 193. 193.
193. 03 193. 04 193. 04 193. 04 193. 05 193. 05 193. 05 193. 05 193. 06 193. 06 193. 06 193. 07 193. 07 193. 07 193. 08 193. 193. 193. 193. 193. 193. 193. 193.	<u>(See A-8)</u> <u>6.00</u> 0 -108, 358 -26, 352 -69, 178 -25, 556 0	For Allocation 7.00 3,161,150 3,478,597 240,113 720,784 300,699		10 00/30/2021	11/29/2021 7: 49 at 193. 193.
193. 03 193. 04 193. 04 193. 04 193. 05 193. 05 193. 05 193. 05 193. 06 193. 06 193. 06 193. 07 193. 07 193. 07 193. 08 193. 193. 193. 193. 193. 193. 193. 193.	<u>(See A-8)</u> <u>6.00</u> 0 -108, 358 -26, 352 -69, 178 -25, 556 0	For Allocation 7.00 3,161,150 3,478,597 240,113 720,784 300,699			193. 193.
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	6.00 0 -108,358 -26,352 -69,178 -25,556 0	7.00 3,161,150 3,478,597 240,113 720,784 300,699			193.
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	0 -108, 358 -26, 352 -69, 178 -25, 556 0	3, 161, 150 3, 478, 597 240, 113 720, 784 300, 699			193.
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	-108, 358 -26, 352 -69, 178 -25, 556 0	3, 478, 597 240, 113 720, 784 300, 699			193.
93.05 19305 MGH FMC SWAYZEE 93.06 19306 MGH PEDIATRIC CTR 93.07 19307 MGH SPECIALTY PHYS 93.08 19308 MGH FMC CONVERSE	-26, 352 -69, 178 -25, 556 0	240, 113 720, 784 300, 699			
93.06 19306 MGH PEDIATRIC CTR 93.07 19307 MGH SPECIALTY PHYS 93.08 19308 MGH FMC CONVERSE	-69, 178 -25, 556 0	720, 784 300, 699			193
93.07 19307 MGH SPECIALTY PHYS 93.08 19308 MGH FMC CONVERSE	-25, 556 0	300, 699			
93.08 19308 MGH FMC CONVERSE	0				193.
	0				193.
	0				193.
93.09 19309 MGH UPLAND HEALTH		86, 280			193.
193.10 19310 MGH MGH WOMENS CTR	o	0			193.
193. 11 19311 MGH MGH PSYCHLATRY	0	0			193.
193. 12 19312 OB/GYN	-108, 239	2, 850, 283			193.
193. 15 19315 MGH RIVER VIEW BLDG	100, 20,	2,000,200			193.
193. 16 19316 MGH NEONATOLOGY	0	888,000			193.
193. 18 19318 MGH WOUND CARE	0	25, 455			193.
194. 00 07963 HEART FAILURE CLINIC	0	59,037			193.
194. 01 07950 MOW	0	57,037			194.
94. 02 07951 MENTAL HEALTH	0	0			194.
	0	0			
94. 03 07952 ADVERTI SI NG	0	251, 419			194.
94. 04 07953 MGH WORK SOLUTIONS	0	868, 383			194.
94. 05 07954 MGH TAYLOR UNIVERSITY	0	965			194.
194. 06 07955 OPI OI D I MPL GRANT	0	295, 134			194.
94. 07 07956 ASTHMA GRANT	0	3, 173			194.
94.08 07957 MGH SMMP BLDG	0	0			194.
94.09 07958 MGH AMBUCARE BLDG	0	0			194.
194.1007959 MGH 106 LYONS BLDG	0	0			194.
94. 11 07960 FAI RMOUNT	0	0			194.
194. 12 07961 GAS CITY	0	0			194.
194. 13 07969 LYONS	0	0			194.
194. 14 07964 WABASH	0	0			194.
194. 15 07965 TOBACCO GRANT	0	54, 146			194.
194.16 07966 HRSA NETWORK DEV PLANNING	0	0			194.
94.17 07967 HRSA OPIOID PLANNING	0	0			194.
94. 18 07962 ECHO GRANT	0	51, 995			194.
94. 19 07968 RURAL QI GRANT	0	169, 342			194.
94.2007970 MGH DIABETES GRANT	0	0			194.
94.21 07971 MGH MGH ORTHO	0	0			194.
94.22 07972 MGH BELLA BLDG	0	0			194.
194. 23 07973 DI ABETES GRANT	o	4, 026			194.
94.24 07974 MGH NORTHWOOD BLDG	0	0			194.
194. 25 07975 MGH MGH ORTHO	o	431, 912			194.
200.00 TOTAL (SUM OF LINES 118 through 199)	-28, 721, 547				200.

	Financial Systems SFFICATIONS		MARION GENERA	Provi der CCN	I: 15-0011	Peri od:		<u>i of Form C</u> Worksheet	
						From 07/01 To 06/30	1/2020 0/2021	Date/Time	
		Increases						11/29/2021	7:49 a
	Cost Center	Line #	Sal ary	Other					
		3.00	4.00	5.00					
	A - SATELLITE OFFICE RECLASS RADIOLOGY-DIAGNOSTIC	54.00	59, 161	8, 980					1.
	ELECTROCARDI OLOGY	69.00	5, 858	1, 582					2.
	TOTALS		65,019	10, 562					
	B - CAFETERIA RECLASS								
	ADMI NI STRATI VE & GENERAL	5.00	0	58, 968					1
00	CAFETERI A	<u> 6.</u> 01	0	<u>1, 624, 8</u> 57					2
	TOTALS		0	1, 683, 825					
00	C - ADMIN DIRECTOR RECLASS	4.00	76, 923	0					1
	ADULTS & PEDIATRICS	30.00	308, 997	0					2
	OPERATI NG ROOM	50.00	111, 747	Ő					3
00	CARDIAC CATHETERIZATION	59.00	32, 784	0					4
00	ELECTROCARDI OLOGY	69.00	65, 569	0					5
	CARDI AC REHAB	69.01	16, 392	0					6
	AMBULANCE SERVICES	95.00	30, 769	0					7
00	GIFT, FLOWER, COFFEE SHOP &	190.00	21, 538	0					8
00	CANTEEN GREAT BEGI NNI NGS/MATERNAL	192.03	8, 432	0					9
	PARI SH NURSI NG	192.03	6, 432 4, 149	0					10
	MGH EXPRESS	192.13	30, 082	0					11
	TOTALS		707, 382	0					
	D - ADVERTISING RECLASS								
00	ADVERTISING	<u> </u>	<u>182, 948</u>	<u>68, 471</u>					1
			182, 948	68, 471					
0	E - LEASED PROPERTY RECLASS ADMINI STRATI VE & GENERAL	5.00	0	119, 605					1
	OPERATION OF PLANT	7.00	0	365, 392					2
	HOUSEKEEPI NG	9.00	0	8, 724					3
0	DI ETARY	10.00	0	28, 016					4
	OPERATING ROOM	50.00	0	175, 737					5
	RADI OLOGY-DI AGNOSTI C	54.00	0	292, 198					6
	CT SCAN	57.00	0	20, 685					7
00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	23, 326					8
00	LABORATORY	60.00	o	85, 093					9
	RESPI RATORY THERAPY	65.00	0	10, 645					10
00	PHYSI CAL THERAPY	66.00	О	28, 969					11
	ELECTROCARDI OLOGY	69.00	0	16, 603					12
	CARDI AC REHAB	69.01	0	14, 995					13
	CLINIC UROLOGY	90.00 192.06	0	56, 635					14
	PARI SH NURSI NG	192.08	0	41, 883 3, 957					16
	LUNG CENTER	192.12	0	29, 357					17
	MGH EXPRESS	192.13	0	10, 455					18
	MGH PHYS PRACT MGMT	192.14	Ő	44, 608					19
	MGH MARION SURGEONS	192.15	О	75, 571					20
	MGH FMC SOUTH	192.17	0	335, 556					21
	MGH FAIRM MED ASSOC	192.18	0	32, 491					22
		192.19	0	64, 856 14, 144					23
	MGH FMC NORTHWOOD MGH FMC GAS CITY	193. 01 193. 02	0	14, 144 80, 729					24 25
	MGH FMC GAS CITY MGH MAR FAM PRACT	193.02 193.04	0	80, 729 50, 893					25
	MGH FMC SWAYZEE	193.04	ő	26, 755					27
	MGH PEDIATRIC CTR	193.06	Ō	60, 338					28
	MGH SPECIALTY PHYS	193.07	О	14, 497					29
	MGH FMC CONVERSE	193.08	0	307					30
	MGH UPLAND HEALTH	193.09	0	1,629					31
	OB/GYN MGH WORK SOLUTIONS	193. 12 194. 04	0	73, 421 3, 302					32
00	TOBACCO GRANT	194.04 194.15	0	3, 302 4, 443					33
	OPIOID IMPL GRANT	194.15	0	7, 023					35
20	TOTALS		0	2, 222, 838					
	F - PHARMACY RECLASS		-						
00	DRUGS_CHARGED_TO_PATIENTS	73.00	0	<u>11, 987, 1</u> 12					1
	TOTALS		0	11, 987, 112					
	G - CT/MRI RECLASS		F00 (0)	400 10-					
00	CT SCAN	57.00	503, 691	439, 427					1
00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	244, 355	213, 179					2
			748, 046	652, 606					1

JEAD.	SEFECATIONS			Provider CCN: 15-001		Worksheet A-6
					From 07/01/2020 To 06/30/2021	Date/Time Prepared
		Increases				11/29/2021 7: 49 ar
	Cost Center	Line #	Salary	Other		
		3.00	4.00	5.00		
00	H - SHORT TERM DI SABILITY REC ADMINI STRATIVE & GENERAL	5.00	0	5, 219		1.
00	PHARMACY	5.00 15.00	0	5, 219 7, 894		2.
0	ADULTS & PEDIATRICS	30.00	0	674		3.
00	OPERATING ROOM	50.00	0	4, 102		4.
0	CARDI AC CATHETERI ZATI ON	59.00	0	4, 315		5.
0	LABORATORY	60.00	0	20, 692		6.
0	ELECTROCARDI OLOGY	69.00	0	4, 937		7.
				47,833		
	I - NURSERY RECLASS		-1	,		
00	NURSERY	43.00	1, 171, 198	291, 435		1.
	TOTALS		1, 171, 198	291, 435		
	J - SMMP HOUSEKEEPING RECLASS		· · · ·			
00	ADMINISTRATIVE & GENERAL	5.00	0	16, 054		1.
00	OPERATION OF PLANT	7.00	0	1, 647		2.
00	HOUSEKEEPI NG	9.00	0	361		3.
00	DI ETARY	10.00	0	611		4.
00	RADI OLOGY-DI AGNOSTI C	54.00	0	22, 781		5.
00	CT SCAN	57.00	0	1, 589		6.
00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 792		7.
	(MRI)	(0.00)				
00		60.00	0	2,874		8.
00	MGH FMC SOUTH	<u> </u>	•	25, 434		9.
			0	73, 143		
00	K - LAUNDRY RECLASS LAUNDRY & LINEN SERVICE	8.00		320, 907		1.
0	TOTALS			320, 907		1.
	L - PHYSICIAN MEDICAL DIRECTO		U	320, 907		
00	ADMI NI STRATI VE & GENERAL	5.00	394, 173	0		1.
	TOTALS		394, 173	— — <u> </u>		
	M - PHYSICIAN SALARIES RECLAS	S				
00	ADMI NI STRATI VE & GENERAL	5.00	2, 833, 410	0		1.
00	SUBPROVIDER – IRF	41.00	60, 125	0		2.
00	RESPI RATORY THERAPY	65.00	5, 478	0		3.
00	PHYSI CAL THERAPY	66.00	3, 145	0		4.
00	CARDI AC REHAB	69.01	15, 406	0		5.
0	EMERGENCY	91.00	4, 460, 529	0		6.
00	PACT REV PHYSICIANS	192.01	771, 186	0		7.
00	UROLOGY	192.06	503, 681	0		8.
00	LUNG CENTER	192.12	522, 789	0		9.
00	MGH EXPRESS	192.13	434, 407	0		10.
00	MGH MARI ON SURGEONS	192.15	1, 095, 588	0		11.
00	MGH MGH MED ONC	192.16	1, 173, 875	0		12.
	MGH FMC SOUTH	192.17	947, 313	0		13.
00	MGH FAIRM MED ASSOC	192.18	165, 729	0		14.
00	MGH FMC MARION MGH FMC NORTHWOOD	192. 19 193. 01	536, 866 597 119	0		15.
00 00		193.01 193.02	597, 119 348, 185	0		16. 17.
00	MGH FMC GAS CITY MGH HOSPITALISTS	193.02 193.03	2, 600, 978	0		17.
00	MGH MAR FAM PRACT	193.03	2, 600, 978	0		18.
00	MGH MAR FAM PRACT MGH FMC SWAYZEE	193.04	91, 938	0		20.
00	MGH PEDIATRIC CTR	193.05	263, 807	0		20.
00	MGH SPECIALTY PHYS	193.00	181, 036	0		22.
00	MGH FMC CONVERSE	193.08	111, 218	õ		23.
00	MGH UPLAND HEALTH	193.09	5, 336	o		24.
00	OB/GYN	193.12	1, 470, 185	ō		25.
00	MGH WOUND CARE	193.18	21, 787	Ö		26.
00	HEART FAILURE CLINIC	194.00	34, 481	Ö		27.
00	MGH WORK SOLUTIONS	194.04	213, 912	Ō		28.
00	MGH MGH ORTHO	194.25	228, 608	Ō		29.
	TOTALS	+	21, 250, 108	— — — ō		
	N - LIABILITY INSURANCE RECLA	ISS		L		
	ADMI NI STRATI VE & GENERAL	5.00	0	21,065		1.
00						

ASSI FI CATI O	Systems NS		MARION GENERAL		CCN: 15-0011	In Lieu Period:	u of Form CMS-2552 Worksheet A-6
						From 07/01/2020 To 06/30/2021	Date/Time Prepare
		Decreases					11/29/2021 7:49 a
	Cost Center	Li ne #	Salary	0ther	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - SATEL	LLITE OFFICE RECLASS	60.00	65, 019	10, 562	0		1.
		0.00	00,017	0			2.
TOTALS			65, 019	10, 562			
B - CAFE DIETARY	TERIA RECLASS	10.00	0	1, 683, 825		1	1.
DIEIARI		0.00	0	1,003,023	(2.
TOTALS			0	1, 683, 825		1	
	N DIRECTOR RECLASS	5.00	25, 687	0			1.
	ADMI NI STRATI ON	13.00	543, 921	0			2.
	E CARE UNIT	31.00	76, 923	0			3.
EMERGENCY	Y	91.00	60, 851	0			4.
		0.00 0.00	0	0			5.
		0.00	0	0		-	7.
		0.00	0	0			8.
		0.00	0	0		-	9.
)		0.00 0.00	0	0			10.
TOTALS			707, 382	ö			
	RTISING RECLASS				-	-1	
TOTALS	RATI VE & GENERAL	<u>5.</u> 00	<u>182, 9</u> 48 182, 948	6 <u>8,471</u> 68,471		<u>)</u>	1.
	ED PROPERTY RECLASS		162, 940	00, 471			
NEW CAP F	REL COSTS-BLDG &	1.00	0	1, 214, 807	10		1.
FI XT		102.05		1 000 001			
OWNED PRO	JPERTLES	192.05 0.00	0	1, 008, 031 0			2.
		0.00	0	0			4.
		0.00	0	0			5.
		0.00 0.00	0	0		-	6.
		0.00	0	0			8.
		0.00	Ō	0			9.
		0.00	0	0			10.
)		0.00 0.00	0	0			11.
)		0.00	0	0			13
		0.00	0	0			14
		0.00	0	0			15
)		0.00 0.00	0	0			16
		0.00	0	0			18
)		0.00	0	0	C		19
)		0.00	0	0			20
)		0.00 0.00	0	0		-	21
		0.00	0	0			23
		0.00	0	0	(-	24
		0.00 0.00	0	0	0		25 26
)		0.00	0	0			27
		0.00	0	0			28
		0.00	0	0			29
		0.00 0.00	0	0	(30 31
		0.00	0	0			31
		0.00	Ō	0	C		33
		0.00	0	0			34
TOTALS		0.00	0	<u>0</u> 0 2, 222, 838			35
	MACY RECLASS		0	2, 222, 030			
PHARMACY			0	<u>11, 987, 1</u> 12		2	1.
TOTALS			0	11, 987, 112			
	RI RECLASS Y-DI AGNOSTI C	54.00	748, 046	652, 606	(1.
		0.00	0	052,000			2.
TOTALS			748, 046	652, 606			
	T TERM DI SABILITY RECL		E 010		-		
PHARMACY	RATI VE & GENERAL	5.00 15.00	5, 219 7, 894	0			1.
	PEDI ATRI CS	30.00	674	0			3.
	G ROOM	50.00	4, 102	0			4.

RECLAS	Financial Systems		MARION GENERA		CCN: 15-0011	Peri od:	u of Form CMS-2552- Worksheet A-6
LOLA						From 07/01/2020	
						To 06/30/2021	Date/Time Prepare
		Decreases					11/29/2021 7: 49 ai
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	-	
	6.00	7.00	8.00	9.00	10,00	<u> </u>	
5.00	CARDI AC CATHETERI ZATI ON	59.00	4, 315	0		0	5.
5.00	LABORATORY	60.00	20, 692	0		0	6.
7.00	ELECTROCARDI OLOGY	69.00	4, 937	0		0	7.
	TOTALS		47,833	0			
	I - NURSERY RECLASS						
. 00	ADULTS & PEDIATRICS	30.00	<u>1, 171, 1</u> 98	291, 435		0	1.
	TOTALS		1, 171, 198	291, 435			
	J - SMMP HOUSEKEEPING RECLASS		I		I	1	
. 00	OWNED PROPERTIES	192.05	0	73, 143		0	1.
2.00		0.00	0	0		0	2.
3.00		0.00	0	0		0	3.
1.00		0.00	0	0		0	4.
5.00		0.00	0	0		0	5.
5.00 7.00		0.00	0	0		0	6.
7.00 3.00		0.00	0	0		0	7.
9.00 9.00		0.00 0.00	0	0		0	9.
, 00	TOTALS		0	73, 143	<u> </u>	5	9.
	K - LAUNDRY RECLASS		U	73, 143	I		
1.00	HOUSEKEEPING	9.00		320, 907		0	1.
. 00	TOTALS		— — — d	320, 907			
	L - PHYSICIAN MEDICAL DIRECTO	R RECLASS		020, 707			
. 00	PACT REV PHYSICIANS	192.01	394, 173	0		0	1.
	TOTALS		394, 173	<u> </u>			
	M - PHYSICIAN SALARIES RECLAS	iS			1		
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 833, 410		0	1.
2.00	SUBPROVI DER – I RF	41.00	0	60, 125		0	2.
3.00	RESPI RATORY THERAPY	65.00	0	5, 478		0	3.
1.00	PHYSI CAL THERAPY	66.00	0	3, 145		0	4.
5.00	CARDI AC REHAB	69.01	0	15, 406		0	5.
5.00	EMERGENCY	91.00	0	4, 460, 529		0	6.
7.00	PACT REV PHYSI CI ANS	192.01	0	771, 186		0	7.
3.00	UROLOGY	192.06	0	503, 681		0	8.
9.00	LUNG CENTER	192.12	0	522, 789		0	9.
0.00	MGH EXPRESS	192.13	0	434, 407		0	10.
1.00	MGH MARI ON SURGEONS	192.15	0	1,095,588		0	11.
2.00	MGH MGH MED ONC	192.16	0	1, 173, 875		0	12.
3.00	MGH FMC SOUTH	192.17	0	947, 313		0	13.
4.00	MGH FAIRM MED ASSOC	192.18	0	165, 729		0	14.
5.00	MGH FMC MARION	192.19	0	536, 866		0	15.
6.00	MGH FMC NORTHWOOD MGH FMC GAS CITY	193.01 193.02	0	597, 119		0	16.
7.00		193.02 193.03	Ű	348, 185		0	17.
8.00	MGH HOSPITALISTS	193. 03 193. 04	0	2,600,978		0	18. 19.
9.00 0.00	MGH MAR FAM PRACT MGH FMC SWAYZEE	193.04 193.05	0	1, 551, 991 91, 938		0	20.
1.00	MGH PEDIATRIC CTR	193.05	0	263, 807		0	20.
2.00	MGH SPECIALTY PHYS	193.00	0	181, 036		0	21.
3.00	MGH FMC CONVERSE	193.07	0	111, 218		0	22.
4.00	MGH UPLAND HEALTH	193.08	0	5, 336		0	23.
5.00	OB/GYN	193. 09	0	1, 470, 185		0	24.
6. 00	MGH WOUND CARE	193.12	0	21, 787		0	25.
7.00	HEART FAILURE CLINIC	193.10	0	34, 481		0	20.
8.00	MGH WORK SOLUTIONS	194.00	0	213, 912		0	27. 28.
9.00	MGH MGH ORTHO	194.04	0	213, 912		0	20.
	TOTALS		— — — o	21, 250, 108		7	27.
	N - LIABILITY INSURANCE RECLA	SS	<u> </u>	2.,200,100			
. 00	MGH MGH ORTHO	194.25	0	21, 065		0	1.
	TOTALS		<u>_</u>	21,065		1	
) Grand Total: Decreases		3, 316, 599	38, 582, 072			500.

Health Financial Systems	MARION GENERA	AL HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0011	Peri Fror To	iod: m 07/01/2020 06/30/2021		pared:
			s				
	Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	5, 191, 830			0	3, 852, 814	0	1.00
2.00 Land Improvements	3, 353, 531	10, 909		0	10, 909	0	2.00
3.00 Buildings and Fixtures	142, 659, 238	7, 816, 669		0	7, 816, 669	0	3.00
4.00 Building Improvements	3, 756, 061	6, 287		0	6, 287	1, 281, 008	4.00
5.00 Fixed Equipment	3, 509, 530	0		0	0	0	5.00
6.00 Movable Equipment	74, 450, 537	3, 658, 835		0	3, 658, 835	-1, 179, 199	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	232, 920, 727	15, 345, 514		0	15, 345, 514	101, 809	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	232, 920, 727	15, 345, 514		0	15, 345, 514	101, 809	10.00
	Ending Balance						
	5	Depreciated					
		Assets					
	6.00	7.00	1				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00 Land	9, 044, 644	0					1.00
2.00 Land Improvements	3, 364, 440	0					2.00
3.00 Buildings and Fixtures	150, 475, 907	0					3.00
4.00 Building Improvements	2, 481, 340	0					4.00
5.00 Fixed Equipment	3, 509, 530						5.00
6.00 Movable Equipment	79, 288, 571	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	248, 164, 432	l o					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	248, 164, 432	0					10.00

Heal th	Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0011	Period: From 07/01/2020 To 06/30/2021		pared:
			SU	JMMARY OF CAF	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	12, 926, 858	0		0 0	0	1.00
3.00	Total (sum of lines 1-2)	12, 926, 858	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12, 926, 858				1.00
3.00	Total (sum of lines 1-2)	0	12, 926, 858				3.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part III Date/Time Prep 11/29/2021 7:4	
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
	1.00		2)		5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	241, 655, 996	0	241, 655, 996	1.000000	0	1.00
3.00 Total (sum of lines 1-2)	241, 655, 996		241, 655, 996			3.00
		TION OF OTHER (F CAPITAL	3.00
Cost Center Description	Taxes	Other Capital-Relate		Depreciation	Lease	
	6,00	d Costs 7.00	through 7) 8.00	9,00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	9.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	(12, 926, 858	-1, 214, 807	1.00
3.00 Total (sum of lines 1-2)	0	0	(12, 926, 858		3.00
		Sl	JMMARY OF CAPI	ΓAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	-18, 183					1.00
3.00 Total (sum of lines 1-2)	-18, 183	0	(0	11, 693, 868	3.00

	Financial Systems MENTS TO EXPENSES		MARION GENER	Provider CCN: 15-0011 P F Ti	eriod: rom 07/01/2020 o 06/30/2021	u of Form CMS-2 Worksheet A-8 Date/Time Prep 11/29/2021 7:4	pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Pasis (Codo (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
. 00	Investment income - other (chapter 2)		0		0.00	0	3.00
	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
	21) Tel evi si on and radi o servi ce (chapter 21)		0		0.00	0	8.00
	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -6, 849, 014		0.00	0 0	9.00 10.00
1. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
2.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
	Laundry and linen service Cafeteria-employees and guests	В	0	CAFETERI A	0. 00 6. 01	0	13.00 14.00
	Rental of quarters to employee and others	D	-1, 835 0	CAFETERIA	0.00	0 0	15.00
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
7.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
3. 00	Sale of medical records and abstracts		0		0.00	0	18.00
	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
0. 00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
2.00	Interest expense on Medicare overpayments and borrowings to		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
4.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
5.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26.00
	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP			FIXT *** Cost Center Deleted ***	2.00	0	27.00
8. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	*** Cost Center Deleted ***	0.00 67.00	0	29.00 30.00
	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
1. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	CAH HIT Adjustment for Depreciation and Interest		0		0.00	О	32.00

	Financial Systems MENTS TO EXPENSES		MARION GENERA	AL HOSPITAL Provider CCN: 15-0011	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:-	
	· · ·			Expense Classification o		11/2//2021 7.	
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.00	FINANCE BANK SERVICE CHARGES	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 01 33. 02	FINANCE DISCOUNT PAYMENTS GAIN ON DISPOSAL	A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00	0	
33.03	XIX ASSESSMENT FEE A/C	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	SELF INSURANCE EXPENSE	A		EMPLOYEE BENEFITS DEPARTMEN		0	
	DEPOSI TI ON-OTHER RETURNED CHECK FEE	B B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00	0	
	PHYSICIAN PRIV APPLICATION	В	-2,650	ADMINISTRATIVE & GENERAL	5.00	0	
33.08	SALE OF MEDICAL RECORDS & ABSTRACTS	В	-49, 999	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
33.09	CHILD SEAT SAFETY INSPECTION	В	-100	ADMI NI STRATI VE & GENERAL	5.00	0	33.09
	HEALTH SCREENING FEES - LAB	В	-40, 293	LABORATORY	60.00	0	
	HEALTH SCREENING FEES - RAD	B B		RADI OLOGY-DI AGNOSTI C ADMI NI STRATI VE & GENERAL	54.00 5.00	0	
JJ. 12	MED STAFF OTHER SCREENING - MED STAF	U U	000	NUMINI JINATI VE & GENERAL	5.00		00.12
	HEALTH SCREENS	В		LABORATORY	60.00	0	
	HEALTH SCREENS REBATE	B B	-	LABORATORY ADMI NI STRATI VE & GENERAL	60.00 5.00	0	33. 14 33. 15
	REBATE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.17	RENTAL OF PROVIDER SPACE BY	В	-1, 200	ADMI NI STRATI VE & GENERAL	5.00	0	33. 17
33. 18	SUPPLIER RENT SPACE UPLAND	В	-1 390	LABORATORY	60.00	0	33. 18
33.19	PAGER RENTAL	В		ADMI NI STRATI VE & GENERAL	5.00	0	
	SALE OF SCRAP, WASTE, ETC.	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 21 33. 22	PCC MARKETING AG EDUCATIONAL WORKSHOP	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00	0	
	OPT HEALTH LINEN SEV	В		LAUNDRY & LINEN SERVICE	8.00	0	•
	AMBULANCE SVC - ASSISTS	В		AMBULANCE SERVICES	95.00	0	
33. 25 33. 26	AMBULANCE SVC - CORONER SVC AMBULANCE SVC - LINEN SERVICES	B B		AMBULANCE SERVICES AMBULANCE SERVICES	95.00 95.00	0	
33.27	AMBULANCE SVC - COMMUNITY	В		AMBULANCE SERVICES	95.00	0	
33. 28	CONTRACT ARU OTH ARU MEDICAL	В	-61, 190	SUBPROVIDER - IRF	41.00	0	33. 28
33. 29	DI RECTO MGH UNCLAIMED OTH 125 MED/CHILD	В	0	ADMI NI STRATI VE & GENERAL	5.00	0	33. 29
33.30	SCHOOL PHYS OTHER SCHOOL PHYS	В	-6,000	ADMI NI STRATI VE & GENERAL	5.00	0	33.30
33.31	PHLEBOTOMY	В		LABORATORY	60.00	0	
	CPR TRAIN OTH AHA COMMUNITY CLINICAL STUDY - OTHER	B		ADMI NI STRATI VE & GENERAL ONCOLOGY	5. 00 60. 01	0	
	SICK CHILD CARE PROGRAM	B		ADULTS & PEDIATRICS	30.00	0	
33.35	ONC. QUAL	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.36 33.37	SETTLEMENTS UNCLAIMED OTHER MONIES	B B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00	0	
55. 57	RECOVERED	b	420		3.00	0	00.07
33.38	VENDING MACHINES	B	-2, 642	CAFETERI A	6.01	0	
33. 39	OTHER ADJUSTMENTS (SPECIFY) (3)	В	0		0.00	0	33.39
33.40	TELEVISION AND RADIO SERVICE	A		OPERATION OF PLANT	7.00	0	
33. 41 33. 42	TELEPHONE SERVICES OPERATING INTEREST INCOME	A B		OPERATION OF PLANT NEW CAP REL COSTS-BLDG &	7.00	0	
		_		FIXT			
33.43 33.44		A		ADMINISTRATIVE & GENERAL	5.00	0	
	LOBBYING COSTS LOBBYING COSTS	A A		PHARMACY RADI OLOGY-DI AGNOSTI C	15.00 54.00	0	
33.46	LOBBYING COSTS	A	-614	ONCOLOGY	60. 01	0	33.46
	ELIMINATING ENTRIES	A		MGH PHYS PRACT MGMT	192.14	0	
	ELIMINATING ENTRIES	A A		MGH WORK SOLUTIONS LUNG CENTER	194.04 192.12	0	
33.50	ELIMINATING ENTRIES	A	-117, 008	MGH MARION SURGEONS	192.15	0	33.50
	ELIMINATING ENTRIES	A		MGH FMC SOUTH	192.17	0	
	ELIMINATING ENTRIES ELIMINATING ENTRIES	A A		MGH FAIRM MED ASSOC MGH FMC MARION	192. 18 192. 19	0	
33.54	ELIMINATING ENTRIES	A	-149, 966	MGH FMC GAS CITY	193.02	0	33.54
	ELIMINATING ENTRIES	A		MGH FMC SWAYZEE	193.05	0	
	ELIMINATING ENTRIES	A A	-69, 178 -60, 686	MGH PEDIATRIC CTR UROLOGY	193.06 192.06	0	
33.58	ELIMINATING ENTRIES	A	-25, 556	MGH SPECIALTY PHYS	193.07	0	33. 58
	ELIMINATING ENTRIES	A		MGH FMC NORTHWOOD	193.01	0	
აა. oU	ELIMINATING ENTRIES	A	- 108, 358	MGH MAR FAM PRACT	193.04	0	33.60

Heal th Financi	ial Systems		MARION GENER	AL HOSPITAL	Inlie	eu of Form CMS-:	2552-10
ADJUSTMENTS T				Provi der CCN: 15-0011	Peri od:	Worksheet A-8	
					From 07/01/2020		
					To 06/30/2021		
				Expense Classification of	n Waskahaat A	11/29/2021 7:	<u>49 am</u>
				To/From Which the Amount is			
					s to be Aujusteu		
C	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.61 ELIMIN	ATING ENTRIES	A	-108, 239	OB/GYN	193.12	0	33.61
33. 62 PHYSI C	I AN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00		33.62
33. 63 ENTERT	AINMENT EXP	A	0	ADMI NI STRATI VE & GENERAL	5.00	0	33.63
33.64 EMPLOY	EE USE OF AUTO	A	-1, 948	ADMI NI STRATI VE & GENERAL	5.00	0	33.64
33.65 DONATI	ONS	A	-269, 481	ADMI NI STRATI VE & GENERAL	5.00	0	33.65
33.66 VHA OP	PORTUNI TY	A	-10	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	33.66
33.67 VHA OP	PORTUNI TY	A	-13, 725	ADMI NI STRATI VE & GENERAL	5.00	0	33.67
33.68 VHA OP	PORTUNI TY	A	-138	OPERATION OF PLANT	7.00	0	33.68
33.69 VHA OP	PORTUNI TY	A	0	ADMI NI STRATI VE & GENERAL	5.00	0	33.69
33.70 VHA OP	PORTUNI TY	A	-62	HOUSEKEEPI NG	9.00	0	33.70
33.71 VHA OP	PORTUNI TY	A	-405	DI ETARY	10.00	0	33.71
33.72 VHA OP	PORTUNI TY	A	-366	CENTRAL SERVICES & SUPPLY	14.00		33. 72
33.73 VHA OP	PORTUNI TY	A	-23, 170	PHARMACY	15.00	0	33.73
33.74 VHA OP	PORTUNI TY	A	-9, 186	ADULTS & PEDIATRICS	30.00	0	33.74
33.75 VHA OP	PORTUNI TY	A	-956	INTENSIVE CARE UNIT	31.00	0	33.75
33.76 VHA OP	PORTUNI TY	A	-189	SUBPROVIDER - IRF	41.00	0	33.76
33.77 VHA OP	PORTUNI TY	A	-30,350	OPERATING ROOM	50.00	0	33.77
33.78 VHA OP	PORTUNI TY	A	-48,081	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 78
33.79 VHA OP	PORTUNI TY	A	-34, 273	CARDIAC CATHETERIZATION	59.00	0	33.79
33.80 VHA OP	PORTUNI TY	A	-39, 384	LABORATORY	60.00	0	33.80
33.81 VHA OP	PORTUNI TY	A	-620	ONCOLOGY	60.01	0	33.81
33.82 VHA OP	PORTUNI TY	A	-1, 314	RESPI RATORY THERAPY	65.00	0	33.82
	PORTUNI TY	A		PHYSI CAL THERAPY	66.00		00.00
33.84 VHA OP	PORTUNI TY	A	-295	ELECTROCARDI OLOGY	69.00	0	00.01
33.85 VHA OP	PORTUNI TY	A	-6	CARDI AC REHAB	69.01	0	33.85
	PORTUNI TY	A		CLINIC	90.00		00.00
	PORTUNI TY	A		EMERGENCY	91.00		00.07
	PORTUNI TY	A		AMBULANCE SERVICES	95.00		
	CALL SVC A/C 7000.2512	А		ADMI NI STRATI VE & GENERAL	5.00		
33.90 MISC R		В		LABORATORY	60.00		
	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5.00		
	ES OTHER REVENUE	В		LABORATORY	60.00		00.72
	ILLB OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5.00		
	ADIOLOGY OTHER REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00		00171
33.95 MISC R		В		ADMI NI STRATI VE & GENERAL	5.00	0	001.70
	(sum of lines 1 thru 49)		-28, 721, 547				50.00
	fer to Worksheet A,						
COI UMN	6, line 200.)						

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT Provider COX: 15-0011 Period: From 07/01/2020 To 06/30/2020 Worksheet A-B-2- to 12/27/2017 2.49 an 11/27/2017 2.		Financial Syste		MARION GENER	RAL HOSPI TAL			eu of Form CMS-	
To 06/30/2021 Date/Propered Display Date/Propered (Final Propered) Display Display <thdisplay< th=""> Display <thdisplay< th=""></thdisplay<></thdisplay<>	PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (CCN: 15-0011	Period: From 07/01/2020		3-2
Identifier Remuneration Component Component Component Identifier Identifier 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1 1.00 11.00 0.00 5.00 6.00 7.00 1 0 1 0<							To 06/30/2021	∣ Date/Time Pre	
Image: 100 2.00 3.00 4.00 5.00 6.00 7.00 1.00 1.00 3.00 4.00 5.00 0.00		Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount		
1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 41.00SUBPROVIDER - IRF 8.732 6.732 0 0 0 1.00 2.00 50.00QPERATING ROM 1.431.367 0 0 0 2.00 0 0 0 0 0 0 2.00 0 0 0 0 0 2.00 0			I denti fi er	Remuneration	Component	Component			
1.00 41.00 UBPROV DER - IRF 8,732 8,732 0 <									
2.00 50.00[pEEATING ROOM 1, 431, 367 0									
3.00 54.00[kADI 0LOCY -DI AGNOSTIC 111,983 111,983 0 0 0 3.00 3.00 <								-	1.00
4.00 59.00 CARDI AC CATHETER JATI ON 60.00 134.992 11.100 134.992 11.100 0 0 0 0 5.00 5.00 60.00 CARDI AC CATHETER JATI ON 60.00 11.100 11.100 11.100 0 0 5.00 5.007 5.007 185 0 0 0 6.00 0	2.00	50.00	OPERATING ROOM	1, 431, 367	1, 431, 367			0	2.00
5.00 60.00 LABORATORY 11.100 11.100 0<	3.00	54.00	RADI OLOGY-DI AGNOSTI C	111, 983	111, 983	(0 0	0	3.00
6.00 69.00 CLECTROCARDIOLOGY 53.655 53.655 0 0 0 6.00 8.00 0.00 0.00 0<	4.00	59.00	CARDIAC CATHETERIZATION	134, 992	134, 992	(0 0	0	4.00
7.00 91.00 [MERGENCY 5,097,185 5,097,185 0	5.00	60.00	LABORATORY	11, 100	11, 100	(o l	0	5.00
7.00 91.00 [MERGENCY 5,097,185 5,097,185 0	6.00	69.00	ELECTROCARDI OLOGY	53, 655	53, 655	(o l	0	6.00
8.00 0.00 <t< td=""><td>7.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>7.00</td></t<>	7.00							0	7.00
9.00 0.00 0.00 0								0	
10.00 1.00 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 14.00 1.00 14.00 1.00 14.00 0.00				0	-			0	
200.00				0				0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Cost Cost Unadjusted RCE Limit Provider Memberships & Continuing Education Provider Smorth Physician Cost of Malpractice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 2.00 50.00 OPERATING ROOM 0 0 0 0 0 0 0 0 0 0 2.00 3.00 54.00 RADI OLGOY-DI AGNOSTIC 0		0.00		6 940 014	6 940 014		°		4
Identifier Limit Unadjusted RCE Limit Remberships & Component Education Component Share of col. of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 2.00 50.00 OPERATING ROM 0	200.00	Wkat Alipo #	Cost Contor/Dhysician				-	- · · · · ·	
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3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0<									
4.00 59.00 CARDIAC CATHETERIZATION 0 <th< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td>-</td><td></td></th<>				-				-	
5.00 60.00 LABORATORY 0 0 0 0 0 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>				-				-	
6.00 69.00 ELECTROCARDIOLOGY 0 <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>0</td> <td></td>				0	0		-	0	
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200.00 Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. Adj usted RCE Limit RCE Di sal I owance Adj ustment Adj ustment Adj ustment Adj ustment Di sal I owance Di sal I owance Di sal I owance Adj ustment Di sal I owance Di owance Di owance D				0	, s		0 ס	0	
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. Adjusted RCE Limit RCE Disal Iowance Adjustment 1.00 2.00 14 14 14 16 16.00 17.00 18.00 1.00 41.00 SUBPROVI DER - I RF 0 0 0 8,732 1.00 2.00 50.00 OPERATI NG ROOM 0 0 0 11.43 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 11.983 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 11.100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 11.100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 5.00 6.00 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 0 0 0 0 0 0 9.00 10.00<		0.00		0	0	(°	0	
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Image: Note of col. Share of col. 14 Image: Note of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 41.00 SUBPROVI DER - I RF 0 0 0 8,732 1.00 2.00 50.00 OPERATI NG ROOM 0 0 1,431,367 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 111,983 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 11,100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 11,100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 5.00 6.00 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 8.00 0 0 8.00 0 0 8.00 9.00 9.00 9.00 9.00 0 9.00 9.00 0 9.00 0 </td <td></td> <td>Wkst. A Line #</td> <td>Cost Center/Physician</td> <td>Provi der</td> <td>Adjusted RCE</td> <td>RCE</td> <td>Adjustment</td> <td></td> <td></td>		Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
Image: Note of the image in the image. Image in the image inthe image in the image in the image in the image in the			I denti fi er	Component	Limit	Di sal I owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 41.00 SUBPROVI DER - IRF 0 0 0 8,732 1.00 2.00 50.00 OPERATI NG ROOM 0 0 0 1,431,367 2.00 3.00 54.00 RADI OLOGY - DI AGNOSTI C 0 0 0 111,983 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 134,992 4.00 5.00 60.00 LABORATORY 0 0 0 5.00 5.00 5.00 6.00 53,655 6.00 7.00 91.00 ELECTROCARDI OLOGY 0 0 0 5,097,185 7.00 8.00 0.00 0 0 0 0 9.00 9.00 0 9.00 9.00 0.00 0 0 0 0 9.00 9.00 9.00 9.00 9.00 10.00				Share of col.					
1.00 41.00 SUBPROVIDER - IRF 0 0 0 8,732 1.00 2.00 50.00 OPERATING ROOM 0 0 0 1,431,367 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTIC 0 0 0 111,983 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 134,992 4.00 5.00 60.00 LABORATORY 0 0 0 11,100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 5.00 8.00 00 0 0 0 0 5.00 6.00 9.00 0.00 0 0 0 0 0 5.00 8.00 0.00 0 0 0 0 0 8.00 0 0 8.00 0 0 8.00 9.00 0 9.00 9.00 10.00 9.00 0 0 0 <									
2.00 50.00 OPERATING ROOM 0 0 1,431,367 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 111,983 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 134,992 4.00 5.00 60.00 LABORATORY 0 0 0 11,100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 5.00 5.00 5.00 6.00 7.00 91.00 EMERGENCY 0 0 0 5.097,185 7.00 8.00 9.00 0 0 8.00 9.00 0 9.00 9.00 0 9.00 9.00 0 9.00 9.00 10.00 9.00 9.00 0 0 0 9.00 10.00 9.00 9.00 10.00 9.00 10.00 9.00 10.00 9.00 10.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00				15.00					
3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 111,983 3.00 4.00 59.00 CARDI AC_CATHETERI ZATI ON 0 0 134,992 4.00 5.00 60.00 LABORATORY 0 0 0 111,100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 5,097,185 7.00 8.00 0.00 0 0 0 0 9.00 0 9.00 0 9.00 0 9.00 0 9.00 10.00 9.00 10.00 9.00 0 0 0 9.00 10.00 9.00 10.00 9.00 0 0 0 0 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00				-			0 8,732		
4.00 59.00 CARDIAC CATHETERIZATION 0 0 134,992 4.00 5.00 60.00 LABORATORY 0 0 0 11,100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 5,097,185 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0 9.00 10.00 9.00 10.00 10.00 9.00 0 10.00 9.00 10.00 9.00 10.00 9.00 10.00 9.00 10.00 <td>2.00</td> <td>50.00</td> <td>OPERATING ROOM</td> <td>0</td> <td>0</td> <td>(</td> <td>0 1, 431, 367</td> <td></td> <td>2.00</td>	2.00	50.00	OPERATING ROOM	0	0	(0 1, 431, 367		2.00
5.00 60.00 LABORATORY 0 0 11,100 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 5,097,185 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0 9.00 10.00 9.00 10.00 9.00 0 10.00 9.00 10.00 </td <td>3.00</td> <td>54.00</td> <td>RADI OLOGY-DI AGNOSTI C</td> <td>0</td> <td>0</td> <td>(</td> <td>0 111, 983</td> <td></td> <td>3.00</td>	3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(0 111, 983		3.00
6.00 69.00 ELECTROCARDIOLOGY 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 5,097,185 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 10.00 0.00 0 0 0 9.00	4.00	59.00	CARDIAC CATHETERIZATION	0	0	(134, 992		4.00
6.00 69.00 ELECTROCARDIOLOGY 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 5,097,185 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 10.00 0.00 0 0 0 9.00	5.00	60.00	LABORATORY	0	0	(11, 100		5.00
7.00 91.00 EMERGENCY 0 0 5,097,185 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 9.00 9.00 0 9.00 10.00 9.00 10.00	6.00	69.00	ELECTROCARDI OLOGY	0	0	(6.00
8.00 0.00 0 0 0 8.00 9.00 0 0 0 9.00 9.00 0 9.00 0 9.00 9.00 10.00 0 0 0 9.00 10.00 </td <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>(</td> <td></td> <td>•</td> <td></td>				0	0	(•	
9.00 0.00 0 0 0 9.00 10.00 0.00 0 0 0 0 10.00									4
10.00 0.00 0 0 0 10.00				-			-		4
				-			-		
		0.00		-					1
	200.00	I	1	1 0		I State Stat	0,017,014	1	1 200. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	MARION GENERA	AL HOSPITAL Provider C	CN: 15-0011 P	In Lie eriod:	eu of Form CMS- Worksheet B	2552-10
				F	rom 07/01/2020 o 06/30/2021	Part I Date/Time Pre	
			CAPI TAL RELATED COSTS			11/29/2021 7:	49 811
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	
		Allocation (from Wkst A		DEPARTMENT		d GENEINE	
		col. 7)	1.00	4.00	4.0	F 00	
	GENERAL SERVICE COST CENTERS		1.00	4.00	4A	5.00	
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	11, 693, 868 16, 022, 716	11, 693, 868 283, 076				1.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	26, 216, 894	3, 606, 728			33, 118, 069	5.00
6.00 6.01	00600 MAI NTENANCE & REPAI RS 00601 CAFETERI A	0 1, 620, 380	0 126, 906	0	-	0 439, 963	
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, 639, 665 317, 424	2, 377, 825 55, 210	171, 246 0	8, 188, 736 372, 634		
9.00	00900 HOUSEKEEPI NG	2, 701, 495	85, 179	0	2, 786, 674	701, 679	9.00
10. 00 13. 00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON	646, 195 1, 145, 127	174, 852 18, 185				
14.00	01400 CENTRAL SERVICES & SUPPLY	494, 436	62, 264	30, 538	587, 238	147, 865	14.00
15.00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 590, 313	80, 215	575, 179	4, 245, 707	1, 069, 061	15.00
	03000 ADULTS & PEDI ATRI CS	6, 860, 979					
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	2, 312, 654 0	285, 428 0	400, 290		754, 984 0	
41.00	04100 SUBPROVI DER – I RF	1, 784, 791	250, 442		2, 275, 081	572, 861	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 1, 462, 633	0	0 254, 169	0 1, 716, 802	0 432, 287	
F0 00	ANCI LLARY SERVI CE COST CENTERS		000.00/				
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	8, 416, 774 0	900, 206 0	682, 911 0	9, 999, 891 0	2, 517, 953 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 717, 496	540, 494	536, 594			
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	965, 392 482, 652	39, 323 46, 613	109, 309 53, 029			
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 143, 577	131, 688				1
60. 00 60. 01	06000 LABORATORY 06001 0NC0L0GY	8, 096, 201 1, 689, 263	377, 531 0	465, 988 220, 288			1
60. 02	06002 RADI ATI ON ONCOLOGY	0	0	0		0	60.02
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 243, 313	175, 113	293, 293	0 2, 711, 719	0 682, 805	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	2, 204, 852	169, 496				
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	1, 010, 932 208, 723	207, 826 33, 863	183, 357 37, 818			
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 11, 987, 112	0	0		0 3, 018, 276	
90.00		1 005 510	107.000	45 104	1 270 502	221 047	
	09000 CLINIC 09100 EMERGENCY	1, 085, 510 5, 565, 481	127, 899 289, 269				
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.00 92.01
92.01	OTHER REIMBURSABLE COST CENTERS	0				0	92.01
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 201, 148	108, 433	229, 740	1, 539, 321	387, 598	95.00
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	134, 527, 996	11, 659, 143	11, 687, 899	129, 875, 378	24, 363, 241	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	27, 185					190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES 19201 PACT REV PHYSI CLANS	0 633, 563	0	0 105, 281			192.00 192.01
192.02	19202 VISITOR MEALS	0	0	0	0	0	192.02
	19203 GREAT BEGINNINGS/MATERNAL 19204 LIFELINE	89, 741	0	18, 847 0			192. 03 192. 04
192.05	19205 OWNED PROPERTIES	418, 960	0	0	418, 960	105, 493	192.05
	19206 UROLOGY 19207 PHYSI CLANS' PRI VATE OFFI CES	1, 259, 792	0	183, 513	1, 443, 305		192.06 192.07
192.08	19211 PARI SH NURSI NG	75, 833	0	12, 763	88, 596	22, 308	192.08
	19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS	0	0		0		192. 09 192. 10
192.11	19208 MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192. 11
	19209 LUNG CENTER 19213 MGH EXPRESS	776, 307 1, 306, 878	0	139, 264 220, 926			
192.14	19210 MGH PHYS PRACT MGMT	2, 026, 650	0	290, 479	2, 317, 129	583, 448	192.14
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	1, 809, 827 1, 375, 169	0	328, 365 254, 772			
	19217 MGH FMC SOUTH	2, 376, 261	0				

Health Financial Systems	MARION GENERA	AL HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 07/01/2020 To 06/30/2021		paradi
				10 00/30/2021	Date/Time Pre 11/29/2021 7:	
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	for Cost	FLXT	BENEFITS		& GENERAL	
	Allocation (from Wkst A		DEPARTMENT			
	col. 7)					
	0	1.00	4.00	4A	5.00	
192.18 19218 MGH FAIRM MED ASSOC	420, 133	0	65, 65	2 485, 785	122, 320	192. 18
192.19 19219 MGH FMC MARION	1, 177, 361	0	197, 36	1 1, 374, 722	346, 152	192. 19
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
193.01 19301 MGH FMC NORTHWOOD	1, 142, 098	0	198, 33		337, 519	1
193.02 19302 MGH FMC GAS CITY	911, 973	0	137, 96		264, 372	1
193. 03 19303 MGH HOSPI TALI STS	3, 161, 150	0	586, 80		943, 727	1
193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE	3, 478, 597	0	566, 31		1, 018, 501	1
193. 06 19306 MGH FMC SWAYZEE 193. 06 19306 MGH PEDIATRIC CTR	240, 113 720, 784	0	36, 60 97, 78		206, 114	193.05
193. 07 19307 MGH SPECIALTY PHYS	300, 699	0	51, 83		88, 768	1
193. 08 19308 MGH FMC CONVERSE	348, 012	0	46, 44			193.08
193. 09 19309 MGH UPLAND HEALTH	86, 280	0	13, 14			193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0		193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0 0	0	193. 11
193. 12 19312 OB/GYN	2, 850, 283	0	433, 38	6 3, 283, 669	826, 821	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	0	193. 15
193.16 19316 MGH NEONATOLOGY	888, 000	0		0 888, 000	223, 597	
193. 18 19318 MGH WOUND CARE	25, 455	0	4, 72			193. 18
194. 00 07963 HEART FAILURE CLINIC	59,037	0	7, 48			194.00
	0	0		0 0		194.01
194. 02 07951 MENTAL HEALTH 194. 03 07952 ADVERTI SI NG	251, 419	0	39, 70	3 291, 122		194. 02 194. 03
194. 04 07953 MGH WORK SOLUTIONS	868, 383	0	109, 28		246, 174	1
194. 05 07954 MGH TAYLOR UNIVERSITY	965	0	3			194.05
194. 06 07955 OPI 0I D I MPL GRANT	295, 134	0	13, 14	-		194.06
194.0707956 ASTHMA GRANT	3, 173	0	58			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		194. 10
194. 11 07960 FAI RMOUNT	0	0		0 0		194.11
194. 12 07961 GAS CI TY	0	0		0 0		194.12
194. 13 07969 LYONS	0	0		0 0		194.13
194.1407964WABASH 194.1507965TOBACCO GRANT	54, 146	0	9, 18	63, 334		194. 14 194. 15
194. 16 07966 HRSA NETWORK DEV PLANNING	54, 140	0	7, 10	0 03, 334		194.15
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0		0 0		194.10
194. 18 07962 ECHO GRANT	51, 995	0	68	4 52,679		194. 18
194. 19 07968 RURAL QI GRANT	169, 342	0	8, 78			194.19
194.2007970 MGH DIABETES GRANT	0	0		0 0	0	194.20
194.2107971 MGH MGH ORTHO	0	0		0 0		194. 21
194.2207972 MGH BELLA BLDG	0	0		0 0		194. 22
194. 23 07973 DI ABETES GRANT	4, 026	0		0 4, 026		194. 23
194. 24 07974 MGH NORTHWOOD BLDG	0	0		0 0		194.24
194. 25 07975 MGH MGH ORTHO	431, 912	0	76, 00	4 507, 916	127, 892	
200.00 Cross Foot Adjustments		0		0		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	164, 644, 632	0 11, 693, 868	16, 305, 79	0 0 2 164, 644, 632		201.00
202.00 TOTAL (Sum TIMES TTO LITUUGH 201)	1 104, 044, 032	11, 073, 000	1 10, 303, 79	- 104, 044, 032	55, 110, 009	202.00

Health Financial Systems	MARION GENERAL	HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	Fr	eriod: com 07/01/2020	Worksheet B Part I	
					Date/Time Pre 11/29/2021 7:	pared: 49 am
Cost Center Description	MAI NTENANCE & REPAI RS	CAFETERI A	CAFETERI A	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS	0					5.00 6.00
6. 01 00601 CAFETERI A	0	2, 187, 249				6. 01
6. 02 00602 CAFETERIA 7. 00 00700 OPERATION OF PLANT	0	2, 163, 401	2, 163, 401 61, 869	10, 312, 512		6. 02 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	0	01,007	107, 438	573, 900	
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	0	0 540	165, 758	0	9.00 10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	47, 502	340, 262 35, 389	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	12, 912	121, 166	87	14.00
15. 00 01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	113, 195	156, 098	0	15.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	303, 367	2, 150, 486	135, 207	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	0	95, 811 0	555, 443 0	31, 954	31.00 40.00
40. 00 04000 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF	0	0	59, 995	487, 360	0 13, 118	
42. 00 04200 SUBPROVI DER	0	О	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	59, 647	0	0	43.00
50. 00 05000 OPERATI NG ROOM	0	0	181, 314	1, 751, 802	68, 068	50.00
51. 00 05100 RECOVERY ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0	0	0	1 051 902	0 25 022	51.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	0	0	146, 536 32, 100	1, 051, 803 76, 523	35, 932 20, 090	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	15, 572	90, 710	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0	35, 954 149, 135	256, 265 734, 676	5, 425 0	59.00 60.00
60. 01 06001 ONCOLOGY	0	Ő	0	0	2, 174	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY 64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	60. 02 64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	64, 361	340, 771	3, 856	
66. 00 06600 PHYSI CAL THERAPY	0	0	46, 329	329, 839	14, 161	
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0	55, 946 8, 948	404, 430 65, 897	5, 036 0	69.00 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 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00 73.00
OUTPATIENT SERVICE COST CENTERS		0	0	0	0	/ 5. 00
90. 00 09000 CLINIC	0	0	19, 231	248, 892	1, 217	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	259, 579	562, 918	217, 224	91.00 92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	00.04
95. 00 09500 AMBULANCE SERVICES	0	0	78, 785	211, 011	18 015	95.00
SPECIAL PURPOSE COST CENTERS	।	q	10,100	211,011	10,010	70.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2 162 401	1 949 439	10, 244, 937	571, 564	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	<u> </u>	2, 163, 401	1, 848, 628	10, 244, 937	571, 504	116.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	67, 575		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 PACT REV PHYSI CLANS	0	0	0	0		192. 00 192. 01
192. 02 19202 VI SI TOR MEALS	0	23, 848	0	0	0	192. 02
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 192. 04 19204 LI FELI NE	0	0	0	0		192. 03 192. 04
192. 05 19205 OWNED PROPERTIES	0	0	0	0		192.04
192. 06 19206 UROLOGY	0	0	39, 327	0		192.06
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19211 PARI SH NURSI NG	0	0	0 3, 709	0		192. 07 192. 08
192. 09 19212 BI OTERRORI SM GRANT	0	0	0	0	0	192. 09
192.10 19214 BREAST PUMPS 192.11 19208 MGH EMERGENCY PHYSICIANS	0	0	0	0		192. 10 192. 11
192. 12 19208 MGH EMERGENCE PHISICIANS	0	0	18, 571	0		192.11
192. 13 19213 MGH EXPRESS	0	0	100 540	0		192.13
192.14 19210 MGH PHYS PRACT MGMT 192.15 19215 MGH MARION SURGEONS	0	0	109, 548 48, 584	0		192. 14 192. 15
192.16 19216 MGH MGH MED ONC	0	Ö	0	0	0	192. 16
192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC	0	0	0	0		192. 17 192. 18
192.19 19219 MGH FMC MARION	0	0	46, 689	0	19	192. 19
193. 00 19300 NONPALD WORKERS 193. 01 19301 MGH FMC NORTHWOOD	0	0	0	0		193. 00 193. 01
193. 02 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CITY	0	0	0	0		193. 01 193. 02

Health Financial Systems	MARION GENERAL	- HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0011 P	eri od:	Worksheet B	
				rom 07/01/2020		
			T	o 06/30/2021	Date/Time Pre	
					11/29/2021 7:	49 am
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6.01	6.02	7.00	8.00	
193. 03 19303 MGH HOSPI TALI STS	0	0	0	-		193.03
193.04 19304 MGH MAR FAM PRACT	0	0	0	-		193.04
193.05 19305 MGH FMC SWAYZEE	0	0	0	° °		193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	22, 826			193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	10, 482			193. 07
193.08 19308 MGH FMC CONVERSE	0	0	0			193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	243	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193.11 19311 MGH MGH PSYCHLATRY	0	0	0	0	0	193. 11
193. 12 19312 OB/GYN	0	0	0	0	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
193.16 19316 MGH NEONATOLOGY	0	0	0	0	0	193. 16
193.18 19318 MGH WOUND CARE	0	0	0	0	0	193. 18
194.0007963 HEART FAILURE CLINIC	0	0	0	0	0	194.00
194. 01 07950 MOW	0	0	0	0	0	194.01
194.0207951 MENTAL HEALTH	0	0	0	0	0	194.02
194. 03 07952 ADVERTI SI NG	0	0	0	0	0	194.03
194.0407953 MGH WORK SOLUTIONS	0	0	0	0	63	194.04
194.0507954 MGH TAYLOR UNIVERSITY	0	0	0	0		194.05
194. 06 07955 OPI OLD I MPL GRANT	0	0	6, 780	0		194.06
194.0707956 ASTHMA GRANT	0	0	150			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. 10 07959 MGH 106 LYONS BLDG	0	0	0	0		194.10
194. 11 07960 FAI RMOUNT	0	0	0	0		194.11
194. 12 07961 GAS CITY	0	0	0	0		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	0	3, 359	-		194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0	0,007	0		194.16
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0	0	0		194.17
194. 18 07962 ECHO GRANT	0	0	266			194. 18
194. 19 07968 RURAL QI GRANT	0	0	4, 482	0		194.10
194. 20 07970 MGH DI ABETES GRANT	0	0	4, 402	0		194. 20
194. 21 07971 MGH MGH ORTHO	0	0	0	0		194.20
194. 22 07972 MGH BELLA BLDG	0	0	0	0		194.21
194. 23 07973 DI ABETES GRANT		0	0	0		194. 22
	0	0	0	0		
194.24 07974 MGH NORTHWOOD BLDG 194.25 07975 MGH MGH ORTHO		0	0	0		194. 24 194. 25
	0	0	0	0	0	
5		_	~	_	_	200.00
201.00 Negative Cost Centers	0	2 107 240	2 142 401	10 212 512		201.00
202.00 TOTAL (sum lines 118 through 201)	I U	2, 187, 249	2, 163, 401	10, 312, 512	573, 900	202.00

DOST ALLOATION - GRIEPAL SERVICE COSTS Provider CDL 15:001 Period arr CDL 10:001 Period arr CDL 10:002 Period arr CDL 10:0	Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lieu	i of Form CMS-2	2552-10
Cost Center Description DUSCREPTING ULLING DUSCREPTING DUSCREPTING <thduscrepting< th=""></thduscrepting<>	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	Fr	om 07/01/2020	Part I	pared [.]
Provide STRATICS						11/29/2021 7:	
Defend Second Constraint 11.00 14.00 15.00 15.00 1.00 Constraint	Cost Center Description	HOUSEKEEPING				PHARMACY	
Image: Service Cast Centres: Image: Service Cast Centres: <th< td=""><td></td><td>0.00</td><td>10.00</td><td>12.00</td><td>SUPPLY</td><td>15.00</td><td></td></th<>		0.00	10.00	12.00	SUPPLY	15.00	
1.00 DOTOR NER CAP NEL COSTS-BLIGG & TAYI 1.00 1.00 DOTOR NER CAP NEL COSTS-BLIGG & TAYI 1.00 1.00 DOTOR NER CAP NEL COSTS-BLIGG & TAYI 1.00 1.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL 0.00 1.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL 0.00 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL 0.00 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL 0.00 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL 0.00 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL 0.00 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL 0.00 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL DEPARTMENT OF A RETERNAL 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL DEPARTMENT OF A RETERNAL 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL DEPARTMENT OF A RETERNAL 0.00 DOTOR NEW TERNET DEPARTMENT OF A RETERNAL DEPARTMENT OF A RETERNAL 0.00 DEPARTMENT OF A RETERNAL <td< td=""><td>GENERAL SERVICE COST CENTERS</td><td>9.00</td><td>10.00</td><td>13.00</td><td>14.00</td><td>15.00</td><td></td></td<>	GENERAL SERVICE COST CENTERS	9.00	10.00	13.00	14.00	15.00	
5: 00 00000 ADM MI ISTRUTY E & FURPAIRS 5: 00 6: 00	1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						
6. 00 Decreb MMINIEARCE & REPAIRS 6. 00							
6.01 0x00 0xFETERIA 6.01 0.02 0x00 0xFEAT MONTAS SERVICE 7.00 0.00 0x00 0xFEAT MONTAS SERVICE 7.00 0.00 0x00 0xFEAT MONTAS SERVICE 7.00 0.00 0x00 0xFEAT MONTAS SERVICE 7.00 0.000 0x000 0xFEAT MONTAS SERVICE 7.00 0.000 0x000 0xFEAT MONTAS SERVICE 9.01 0.000 0x000 0x000 0x000 0x000 0x000 0x000							
2. 00 00/200 DEERAT MO OF PLANT 7. 00 <td>6. 01 00601 CAFETERI A</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	6. 01 00601 CAFETERI A						
8. 00 00000 LAUNDRY & LINEN SERVICE 3. 654, 111 1. 4.26, 700 8. 00 8. 00 00000 0. 0000 8. 00 0. 00000 0. 00000 0. 00000							
9. 00. 00000 (HURSPERTPHINE 3. 6.94, 111 1, 4.26, 200 9. 00 13. 00 01300 (HURSPERT ALIAN ISTATION 15, 357 1, 645, 947 1, 645, 947 10, 00 13. 00 01300 (HURSPERT ALIAN ISTATION 15, 357 16, 357 0 9. 00 9.							
13.00 01300 MURSI NG ADM IN STRATION 16, 65, 70 0 1, 84, 647 1 1 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 0 0 0 1 0 1 0 1 0	9. 00 00900 HOUSEKEEPI NG						
14 ADD 01 ADD CENTRAL SERVICES & SUPPLY 61, 754 0 0 65, 629, 800 15, 00 14 ADD INFAL PRANACY 16, 757 0 0 16, 000 0 6, 629, 800 15, 00 16, 00				1 845 047			
INNET LAT. BUTLINE SERVICE COST CENTERS 968, 323 964, 323 966, 966 966, 966			Ű		951, 052		
03:000 03:000 ADULTS A PEDIATRLCS 99:6,323 80:4,900 444,025 10:4,616 0		45, 799	0	0	0	5, 629, 860	15.00
13.100 03100 [MILESIN C CARE UNI T 113.196 140.000 140.000 00		968 323	804 900	444 075	104 616	0	30.00
14.100 04100 SUBERVOIDER - 1 INF 137, 177 87, 822 9, 511 0 42, 00 04300 NURSERV 0 0 67, 312 0 0 42, 00 04300 NURSERV 0 0 67, 312 0 0 42, 00 04300 NURSERV 0 0 0 169, 907 123, 637 0 50, 00 04100 SCI00 OFEANING KOMSTIC 207, 731 0 0 0 0 0 0 57, 00 0 57, 00 0 57, 00 0 57, 00 58, 00 58, 00 57, 06, 0 60, 00							
12 0 0 0 0 0 0 12.00 ALS 0 ASS 0		0	0	0	0		
43.00 04300 NURSERY 0 0 87.312 0 0 43.00 AMULLARY SERVICE COST CENTERS 0 160,987 123,637 0 0 0 0 0 0 0 0 0 0 50.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.		1 1		87,822			
50. 00 GEOCO DEFEATING ROOM 484, 162 0 169, 987 122, 637 0 50. 00 51. 00 DSCOVERY ROOM 0 <td< td=""><td>43.00 04300 NURSERY</td><td>-</td><td>-</td><td>87, 312</td><td>-</td><td></td><td></td></td<>	43.00 04300 NURSERY	-	-	87, 312	-		
51.00 05.100 PCOVERY PCOM 0 0 0 0 0 0 0 51.00 50.00 60		404 17 2	0	1/0 007	100 / 07	0	
57.00 OS7200 (C SCAN 11,450 0 0 0 0 0 0 57.00 58.00 OS500 (ARDIAC CATHETER JATION 65,427 0 52,630 38,042 0 99.00 60.00 OGCOU (ARDIATION ONCOLOGY 0 <td< td=""><td></td><td></td><td></td><td></td><td>_</td><td></td><td></td></td<>					_		
58. 00 0 bosed Market Into RESONANCE (MRE) 0			0	0	19, 021		
55:00 05500 CARDIA C CATHETERIZATION 65,427 0 52,630 38,042 0 9 00 60:00 166001 NACUCACY 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td></td>			0	0	0	-	
60.01 0x001 0x00.0Cy 0			0	52, 630	38, 042		
60.02 0002 RADIATION ONCLOOY 0 <td></td> <td></td> <td>0</td> <td>0</td> <td>57, 063</td> <td></td> <td></td>			0	0	57, 063		
64.00 O O O O O 64.00 65.00 OSCOR RESPIRATORY THERAPY 137, 397 O 94, 213 19, 021 O 66.00 66.00 OSCOR RESPIRATORY THERAPY 137, 397 O 67, 817 O O 66.00 67.00 OSCOR LECTERCOADDIOLOCY B8, 327 O 81, 895 28, 552 O 69, 00 67.00 OSCOR DELICE TRECARGED TO PATIENTS O O O O 0 0 0 72.00 0		0	0	0	0		
66.00 00 67.817 0 67.817 0 66.00 69.00 GROOP ELECTROCARDIOLOGY B8.327 0 B18.995 28.532 0 69.01 71.00 OTOMEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71.00 0 0 0 0 0 0 71.00 70.00 0 0 0 0 0 0 0 0 0 0 71.00 70.00 0 0 0 0 0 0 71.00 70.00 0		0	0	0	0	-	
69.00 00 0000 CARDIAC REHAB 98, 141 0 13, 096 28, 532 0 69, 00		1	0		19, 021	-	
69.01 06901 CARDIAC REHAB 98, 141 0 13, 098 0 69, 01 71.00 07000 MPL DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07200 MPL DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07200 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 90.00 00000 CLINIC 65,427 0 28,151 0 0 90.00 91.00 92010 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.01 92.01 09200 DESERVATION BEDS (SUSTINCT PART) 0 0 0 0 95.00 95.00 95.00 95.00 95.00 95.01 0 95.00 95.00 95.01 0 95.00 95.01 0 <td< td=""><td></td><td></td><td>0</td><td></td><td>0 28 532</td><td></td><td></td></td<>			0		0 28 532		
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73.00 OPTICAD CRUCES CHARGED TO PATLENTS O O O Sequence 73.00 73.00 90.00 00000 CLI NI C COST CENTERS 0 28.151 0 0 90.00 91.00 91.00 91.00 91.00 91.00 91.00 92.00 9		-	0	Ű	0		
OUTPATE INT SERVICE COST CENTERS 90.00 00000 CLINC 65,427 0 28,151 0 0 90.00 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 732,785 20,899 379,976 47,553 0 91.00 92.00 92.01 9201 DESERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.01 9200 95.00 9500 MURSABLE COST CENTERS 95.00 9500 9500 9500 9500 95.00 9500 95.00 95.00 95.00 95.00 95.00 95.01 95.00		-	0	-	0		
91 00 09100 ENERGENCY 732, 785 20, 899 379, 976 47, 553 0 91, 00 92.00 09200 DSERVATI ON BEDS (IDISTINCT PART) 0 0 0 0 92.01 09201 (DISERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 92.01 95.00 </td <td>OUTPATIENT SERVICE COST CENTERS</td> <td></td> <td>9</td> <td></td> <td>۲ ۲</td> <td>0,02,,000</td> <td>/ 01 00</td>	OUTPATIENT SERVICE COST CENTERS		9		۲ ۲	0,02,,000	/ 01 00
92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART) 0 </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td>					-		
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95.00 OP500[AMBULANCE SERVICES 22,900 0 115.326 9,511 0 SPECIAL PURPOSE COST CENTERS	92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 113.00 INTEREST EXPENSE 113.00 113.00 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 601, 769 1, 108, 976 1, 762, 552 485, 039 5, 629, 860 118.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6, 543 0 0 0 0192.00 192.01 192.01 PACT REV PHYSI CLANS 0 0 0 0192.02 192.02 19203 GREAT BEGI NNI NOS/MATERNAL 0 0 0 0 192.03 192.03 19204 J204 ISUMI NOS/MATERNAL 0 0 0 0 192.03 192.04 19204 DROPERTI ES 0 0 0 0 192.02 192.05 UNRD. PROPERTI ES 0 0 0 0 0 192.06 192.06 19205 WINED FROPERTI ES 0 0 0 0 0 0		22 900	0	115 326	9 511	0	95 00
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NONRE I MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 6,543 0		2 601 760	1 109 074	1 740 550	495 020	E 400 940	
192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 192.01 19202 VISI TOR MEALS 0 0 0 0 192.02 192.02 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.02 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.03 192.04 19205 19205 WRDD PROPERTI ES 0 0 0 0 192.04 192.06 19206 UROLOGY 0 0 0 0 192.05 192.07 19207 PHYSI CI ANS' PRI VATE OFFI CES 13,085 0 0 0 192.07 192.08 19211 PARI SH NURSI NG 6,543 0 0 0 192.08 192.10 19212 BI OTERRORI SM GRANT 0 0 0 0 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02		3,001,709	1, 106, 976	1, 702, 552	405, 039	5, 029, 800	116.00
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192.08 19211 PARI SH NURSI NG 6, 543 0 0 0 192.08 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.09 192.10 19214 BREAST PUMPS 0 0 0 0 192.09 192.11 19208 MGH EMERGENCY PHYSI CI ANS 0 0 0 192.10 192.12 19209 LUNG CENTER 0 0 0 192.12 192.13 IP213 MGH EMERGENCY PHYSI CI ANS 0 0 0 192.12 192.13 IP214 NGH EXPRESS 0 0 0 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 26,171 0 0 0 192.14 192.15 IAGH MARI ON SURGEONS 0 0 0 0 192.15 192.16 19217 MGH FMC SOUTH 0 0 0 0 192.17 192.18 IAGH MED ONC 0 0 0 0 192.18 192.17 192.18 19217 <t< td=""><td>192. 06 19206 UROLOGY</td><td>0</td><td>0</td><td>0</td><td>38, 042</td><td>0</td><td>192.06</td></t<>	192. 06 19206 UROLOGY	0	0	0	38, 042	0	192.06
192.09 19212 BI OTERRORI SM GRANT 0 0 0 192.09 192.10 19214 BREAST PUMPS 0 0 0 0 192.10 192.11 19208 MGH EMERGENCY PHYSI CLANS 0 0 0 192.11 192.12 19209 LUNG CENTER 0 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 0 0 192.13 192.14 19210 MGH MARI ON SURGEONS 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.15 192.17 19217 MGH FMC SOUTH 0 0 0 0 192.15 192.17 19217 MGH FMC SOUTH 0 0 0 0 192.17 192.19 19217 MGH FMC SOUTH 0 0 0 192.17 192.18 19218 MGH FMC MARI MED ASSOC 0 0 0 192.18 192.19 192.19 MGH FAIRM MED ASSOC 0			0	0	0		
192.10 19214 BREAST PUMPS 0 0 0 192.10 192.11 19208 MGH EMERGENCY PHYSICIANS 0 0 0 0 192.11 192.12 19209 LUNG CENTER 0 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 76,971 19,021 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 26,171 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.16 192.17 19217 MGH MARI ON SURGEONS 0 0 0 192.16 192.17 19217 MGH MGH MED ONC 0 0 0 192.16 192.17 19217 MGH FAC SOUTH 0 0 0 192.17 192.18 19218 MGH FAC MARI ON 0 0 0 192.19 192.19 19219 MGH FAC MARI ON 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 <td></td> <td>0, 543</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0, 543	0	0	0		
192.12 19209 LUNG CENTER 0 0 0 0 192.12 192.13 19213 MGH EXPRESS 0 0 76,971 19,021 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 26,171 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.15 192.16 19216 MGH MED ONC 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 192.17 192.18 MGH FAI RM MED ASSOC 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 192.17 192.19 19219 MGH FAI RM MED ASSOC 0 0 0 192.19 192.19 19219 MGH FMC MARI ON 0 0 0 192.19 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00	192.10 19214 BREAST PUMPS	0	0	0	Ō	0	192. 10
192.13 19213 MGH EXPRESS 0 0 76,971 19,021 0 192.13 192.14 19210 MGH PHYS PRACT MGMT 26,171 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 0 192.15 192.16 19216 MGH MAGH MED ONC 0 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 192.17 192.18 19219 MGH FAI RM MED ASSOC 0 0 0 192.18 192.19 19219 MGH FAI RM MED ASSOC 0 0 0 192.19 192.19 19219 MGH FAI RM MED ASSOC 0 0 0 192.19 192.19 19219 MGH FAI RM MED ASSOC 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00		0	0	0	0		
192.14 19210 MGH PHYS PRACT MGMT 26,171 0 0 0 192.14 192.15 19215 MGH MARI ON SURGEONS 0 0 0 192.15 192.16 19216 MGH MGH MGH DONC 0 0 0 192.16 192.17 19217 MGH FMC SOUTH 0 0 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 192.18 192.19 19219 MGH FAI RM MED ASSOC 0 0 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 193.00		0	0	76, 971	19, 021		
192.16192.16MGH MGH MED ONC000192.16192.1719217MGH FMC SOUTH00038,0420192.17192.1819218MGH FAI RM MED ASSOC00000192.18192.1919219MGH FMC MARI ON000028,5320192.19193.0019300NONPAI D WORKERS00000193.00	192.14 19210 MGH PHYS PRACT MGMT	26, 171	0	0	О	0	192. 14
192.17 19217 MGH FMC SOUTH 0 0 0 38,042 0 192.17 192.18 19218 MGH FAI RM MED ASSOC 0 0 0 0 192.18 192.19 19219 MGH FMC MARI ON 0 0 0 28,532 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00		0	0	0	57,063		
192.19 MGH FMC MARI ON 0 0 28, 532 0 192.19 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00		0	0	0	38, 042		
193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00		0	0	0	0		
		0	0	0	28, 532 0		
		0	0	0	9, 511		

Health Financial Systems	MARION GENERAL	HOSPI TAL			In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0011		riod: om 07/01/2020 06/30/2021	Worksheet B Part I Date/Time Pre 11/29/2021 7:	
Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG ADMI NI STRATI	ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	9.00	10.00	13.00		14.00	15.00	
193.02 19302 MGH FMC GAS CITY	0	0)	0	9, 511	C	193.02
193. 03 19303 MGH HOSPI TALI STS	0	0		0	0	C	193.03
193.04 19304 MGH MAR FAM PRACT	0	0		0	57, 063	C	193.04
193.05 19305 MGH FMC SWAYZEE	0	0		0	9, 511	0	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0		0	9, 511	C	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0	0	C	193.07
193.08 19308 MGH FMC CONVERSE	0	0		0	9, 511	C	193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0	19, 021	C	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	0	0	193. 10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0	0	0	193. 11
193. 12 19312 OB/GYN	0	0		0	142, 653	0	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	0	0		0	0	0	193.16
193.18 19318 MGH WOUND CARE	0	0		0	0	0	193.18
194.00 07963 HEART FAILURE CLINIC	0	0)	0	0	C	194.00
194. 01 07950 MOW	0	171, 694	Ļ	0	0	C	194.01
194.0207951 MENTAL HEALTH	0	145, 530)	0	0	C	194.02
194. 03 07952 ADVERTI SI NG	0	0		0	0		194.03
194.04 07953 MGH WORK SOLUTIONS	0	0		0	19, 021	0	194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0	0		194.05
194.06079550PLOID IMPL GRANT	0	0		0	0		194.06
194.0707956ASTHMA 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		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	0)	0	0		194.15
194. 16 07966 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. 19 07968 RURAL QI GRANT	0	0)	0	0		194.19
194. 20 07970 MGH DI ABETES GRANT	0	0		0	0		194. 20 194. 21
194. 21 07971 MGH MGH ORTHO	0	0		0	0		
194. 22 07972 MGH_BELLA_BLDG 194. 23 07973 DLABETES_GRANT	0	0		0	0		194. 22 194. 23
194. 23 07973 DTABETES GRANT 194. 24 07974 MGH NORTHWOOD BLDG	0	0		0	0		194. 23
194. 25 07975 MGH MORT NORTHWOOD BLDG	0	0		0	0		194. 24
200.00 Cross Foot Adjustments	0	0		0	0	U	200.00
201.00 Negative Cost Centers		0		0	0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	3, 654, 111	1, 426, 200	1, 845, 9	147	951,052	5, 629, 860	•
	5,004,111	1, 720, 200	1 1,040,9	"	/51,052	5, 027, 000	1202.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN	l: 15-0011	Period: From 07/01/2020	Worksheet B Part I
				To 06/30/2021	Date/Time Prepared: 11/29/2021 7:49 am
Cost Center Description	Subtotal	Intern &	Total		11/2//2021 /. 4/ dill
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26.00	_	
GENERAL SERVICE COST CENTERS	1				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					1.00
5. 00 00500 ADMINI STRATI VE & GENERAL					5.00
6. 00 00600 MAI NTENANCE & REPAI RS 6. 01 00601 CAFETERI A					6. 00 6. 01
6. 02 00602 CAFETERIA					6. 02
7.00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8.00 9.00
10. 00 01000 DI ETARY					10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13.00 14.00
15. 00 01500 PHARMACY					15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	44 405 045		4/ 405 04	-	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	16, 425, 917 4, 934, 602		16, 425, 91 4, 934, 60		30.00 31.00
40. 00 04000 SUBPROVIDER - IPF	C	0		0	40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	3, 799, 890		3, 799, 89	0	41.00 42.00
43. 00 04300 NURSERY	2, 296, 048	-	2, 296, 04	.8	42.00
ANCI LLARY SERVI CE COST CENTERS	45 004 044		45 00/ 04		F0.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	15, 296, 814	1	15, 296, 81	4	50.00 51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 714, 672	0	8, 714, 67		54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 534, 696		1, 534, 69 835, 19		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 483, 022		3, 483, 02		59.00
60. 00 06000 LABORATORY	12, 314, 794		12, 314, 79		60.00
60. 01 06001 0NC0L0GY 60. 02 06002 RADI ATI 0N ONC0L0GY	2, 392, 546	1	2, 392, 54	.6 0	60. 01 60. 02
64.00 06400 INTRAVENOUS THERAPY	0	0		0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	4, 054, 143		4, 054, 14 3, 980, 62		65.00 66.00
69. 00 06900 ELECTROCARDI OLOGY	2, 419, 331		2, 419, 33		69.00
69. 01 06901 CARDI AC REHAB	537,093	0	537, 09	3	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS				0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 635, 248	0	20, 635, 24	8	73.00
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	1, 963, 458		1, 963, 45	.8	90.00
91. 00 09100 EMERGENCY	11, 792, 487		11, 792, 48		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	C	0		0	92. 01
95. 00 09500 AMBULANCE SERVICES	2, 382, 467	0	2, 382, 46	7	95.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE	1	I I			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	119, 793, 044	0	119, 793, 04	4	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	157, 468		157, 46	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	157,400		157,40	0	190.00
192. 01 19201 PACT REV PHYSI CLANS	924, 883		924, 88		192.01
192. 02 19202 VI SI TOR MEALS 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	23, 848		23, 84 142, 35		192. 02 192. 03
192. 04 19204 LI FELI NE	C	0		0	192.04
192. 05 19205 OWNED PROPERTI ES 192. 06 19206 UROLOGY	524, 453		524, 45 1, 884, 09		192. 05 192. 06
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES	13, 085		13, 08		192.00
192. 08 19211 PARI SH NURSI NG	121, 156	0	121, 15	6	192.08
192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS				0	192. 09 192. 10
192.11 19208 MGH EMERGENCY PHYSICIANS				0	192. 11
192. 12 19209 LUNG CENTER 192. 13 19213 MGH EXPRESS	1, 164, 681 2, 009, 250		1, 164, 68 2, 009, 25		192. 12 192. 13
192. 13 19213 MGH EXPRESS 192. 14 19210 MGH PHYS PRACT MGMT	3, 036, 296		2, 009, 25 3, 036, 29		192. 13
192.15 19215 MGH MARI ON SURGEONS	2, 782, 231	0	2, 782, 23	1	192. 15
192.16 19216 MGH MGH MED ONC 192.17 19217 MGH FMC SOUTH	2, 040, 357 3, 460, 727		2, 040, 35 3, 460, 72		192. 16 192. 17
192.18 19218 MGH FAIRM MED ASSOC	608, 115	5 O	608, 11	5	192. 18
192.19 19219 MGH FMC MARION	1, 796, 114	0	1, 796, 11	4	192. 19

Health Financial Systems	MARION GENERA	AL HOSPI TAL			In Lieu of Form CMS	-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0011	Peri o		
					07/01/2020 Part 06/30/2021 Date/Time Pr	enared
				10	11/29/2021 7	': 49 am
Cost Center Description	Subtotal	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown Adjustments				
	24.00	25.00	26.00			
193.00 19300 NONPAI D WORKERS	0	0		0		193.00
193.01 19301 MGH FMC NORTHWOOD	1, 687, 578	0	1, 687,	578		193.01
193.02 19302 MGH FMC GAS CITY	1, 324, 163	0	1, 324,	163		193. 02
193. 03 19303 MGH HOSPI TALI STS	4, 691, 678	0	1,0,1,			193.03
193.04 19304 MGH MAR FAM PRACT	5, 120, 968	0	5, 120,			193.04
193.05 19305 MGH FMC SWAYZEE	355, 904	0	,			193.05
193. 06 19306 MGH PEDIATRIC CTR	1,057,028	0	.,,			193.06
193.07 19307 MGH SPECIALTY PHYS	451, 785	0	1017			193. 07 193. 08
193. 08 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH	503, 345	0	503,			193.08
193. 10 19310 MGH MGH WOMENS CTR	143, 723	0	143,	0		193. 09
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0		193.10
193. 12 19312 OB/GYN	4, 253, 143	0		U		193.12
193. 15 19315 MGH RIVER VIEW BLDG	0	0		0		193.15
193.16 19316 MGH NEONATOLOGY	1, 111, 597	0	1, 111,	597		193.16
193.18 19318 MGH WOUND CARE	37, 783	0	37,			193. 18
194.0007963 HEART FAILURE CLINIC	83, 270	0	83,	270		194.00
194. 01 07950 MOW	171, 694	0				194.01
194.0207951 MENTAL HEALTH	145, 530	0				194. 02
194. 03 07952 ADVERTI SI NG	364, 426	0				194.03
194. 04 07953 MGH WORK SOLUTIONS	1, 242, 923	0	., ,			194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	1,249	0		249		194.05
194. 06 07955 OPI 0I D I MPL GRANT 194. 07 07956 ASTHMA GRANT	392, 682 4, 854	0		854		194.06 194.07
194. 08 07957 MGH SMMP BLDG	4, 054	0	4,	0		194.07
194. 09 07958 MGH AMBUCARE BLDG	0	0		0		194.00
194. 10 07959 MGH 106 LYONS BLDG	0	0		0		194.10
194. 11 07960 FAI RMOUNT	0	0)	0		194.11
194. 12 07961 GAS CI TY	0	0		0		194.12
194. 13 07969 LYONS	0	0		0		194.13
194. 14 07964 WABASH	0	0		0		194. 14
194.1507965TOBACCO GRANT	82, 640	0	82,			194. 15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0		0		194.16
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0		0		194.17
194. 18 07962 ECHO GRANT	66, 209	0	66,			194. 18 194. 19
194.19 07968 RURAL QI GRANT 194.20 07970 MGH DIABETES GRANT	227, 455	0	227,	455		194. 19
194. 21 07971 MGH MGH ORTHO	0	0		0		194.20
194. 22 07972 MGH BELLA BLDG	0	0		õ		194. 21
194. 23 07973 DI ABETES GRANT	5,040	0	5.	040		194.23
194. 24 07974 MGH NORTHWOOD BLDG	0	0	-,	0		194.24
194.25 07975 MGH MGH ORTHO	635, 808	0	635,	808		194. 25
200.00 Cross Foot Adjustments	0	0		0		200. 00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	164, 644, 632	0	164, 644,	632		202.00

4. 00 00400 LMPLOYEE BENEFITS DEPARTMENT 0 283,076 283,076 283,076 283,076 4.0 5. 00 00500 AMM INSTRATIVE & GENERAL 0 3,600,728 3,600,728 3,600,728 57,227 3,663,955 5.0 6. 00 00500 AMM INSTRATIVE & GENERAL 0 0,26,906 126,906 0 46,674 6.0 6. 02 00500 OPERATION OF PLANT 0 2,377,825 2,377,825 2,973 228,114 7.0 7.00 0700 OVO OPERATION OF PLANT 0 7,7828 0 7,7828 0 7,7828 0 7,7828 0 7,7828 0 7,7828 0 10,300 100,000 INTARY 11,885 18,185 18,185 18,185 18,182,213 15.0 0 150,000 OND INTARY 5,210 0 10,000 OND INTARY	ALLOCA			Provider CC	F	eriod: rom 07/01/2020	Worksheet B Part II	
Cost Center Description Directly billarded bil		Cost Center Description						
Cost Center Description Directly regimenting Related Costs Network Subtotal EMPLOYEE BLANE (12) (12) ADMINISTRATIVE (12) ADMINISTRATIVE (12) ADMINISTRATIVE (12) ADMINISTRATIVE (12) Cost Center Description 0 1.00 24 4.00 5.00 1.00 00100/mit CAP (42) 5.00 5.00 5.00 5.00 1.00 00000/mit CAP (42) 5.00 5.00 0.00 6		Cost Center Description				0 00/ 50/ 2021		
Directly Assigned New Capit Inf Walk and easts BUB BLD 6 First Subtotal First BUR MENTER Directly Science Active Presentation Active Science CENERAL SERVICE COST CENTERS 0 1.00 2A 4.00 5.00 Directly Assigned Autors 0 1.20 2A 1.00 2A 4.00 5.00 Directly Assigned Autors 0 1.00 2.37 2.07 <td></td> <td>Cost Center Description</td> <td></td> <td>CAPI TAL</td> <td></td> <td></td> <td>11/29/2021 7.</td> <td>49 811</td>		Cost Center Description		CAPI TAL			11/29/2021 7.	49 811
Acsigned feer Bol street 00100 (REV CAP EL, COST-SELG, A FLXT 00100 (REV CAP EL, COST-SELG, A FLXT 000100 (REV CAP EL, COST-SELG, A FLXT 000000 (REV CAP CAP EL, COST-SELG, A FLXT 00000 (REV CAP CAP EL, COST-SELG, A FLXT 0000000 (REV CAP CAP EL, COST-SELG, A FLXT 0000000 (REV REV CAP CAP EL, COST-SELG, A FLXT 0000000 (REV REV CAP EL, REV LL, RESPUEL E, COST-SELG, A FLXT 0000000 (REV REV CAP EL, REV LL, RESPUEL E, COST-SELG, A FLXT 0000000 (REV REV CAP EL, REV LL, RESPUEL E, COST-SELG, A FLXT 0000000 (REV REV REV CAP EL, REV LL, REV LL, REV REV CAP EL, REV LL, REV REV REV CAP EL, REV REV REV REV REV CAP EL, REV		LOST CENTER DESCRIPTION						
Control Description Description 1.00 24 4.00 5.00 1.00 20.0000 24.000 5.00 1.00 20.0000 28.076 28.076 28.076 1.00 20.0000 28.076 28.076 28.076 5.00 1.00 20.0000 28.076 28.076 28.076 28.076 5.00 1.00 20.0000 20.0000 20.000 0.0000 4.000 5.00 5.00 0.0000 20.0000 20.000 0.0000 4.000 5.00					Subtotal			
EMERAL STRVICE COST CENTRES 0 1.00 2A 4.00 5.00 1000 ORES CAP REL COSTS-BLG. A FLXT 0 200,00,728 200,0728 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>d dementie</td> <td></td>			0				d dementie	
Elemental Stervice Cost Centress 0 001001000 (Cost Cast Eless el Int T) 0 218.076 283.076				1.00	24	4.00	F 00	
1.00 00100 (HER CAP REL COSTS-BLO & FLXT 0 283,076 283,076 283,076 4.0 4.0 0.0000 (MAUN TS MARE A REPAIRS 0 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 3,060,728 4,00 4,0 <td></td> <td>GENERAL SERVICE COST CENTERS</td> <td>0</td> <td>1.00</td> <td>ZA</td> <td>4.00</td> <td>5.00</td> <td></td>		GENERAL SERVICE COST CENTERS	0	1.00	ZA	4.00	5.00	
5. 00 00500 (MULH INSTRATI VF & GREPALL 0 3. 400, 728 J. 3. 400, 728 J. 3. 400, 728 J. 3. 400, 728 J. 4. 00 D 6. 00 0	1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
6. 00 00000 (MAI NTENANCE & REPAI INS 0			0					4.00
6. 01 00601 CAFETERIA 0 126, 906 126, 906 0 48, 674 6. 0 7. 00 00700 (PREATION OF PLANT 0 2, 377, 325 2, 377, 325 2, 973 228, 114 7. 0 8. 00 00800 (LAMORY & LINN SERVICE 0 85, 210 0 10. 308 80 9. 00 00900 (AUSERLET) MS 0 18, 185 171, 172 77, 628 9. 00 13. 00 01400 (CENTRAL SERVICES & SUPPLY) 0 62, 204 62, 204 63, 216 9. 964 118, 273 15. 00 10. 00 01400 (CENTRAL SERVICES & SUPPLY) 0 62, 204 62, 204 62, 204 63, 216 77 62, 310 11. 00. 01000 (INTENS NA ANN ISTRATION 0 288, 128 288, 128 288, 428 6, 448 33, 20 13. 00 01300 (INTENS NA CANN ISTRATION 0 288, 128 288, 428 6, 448 33, 20 13. 00 01300 (INTES NE CANNE UNE COST CENTERS 0 0 0 0 0 0 0 0 128, 428 288, 428 6, 448 30, 127, 7857 31, 00 30, 030			0	3, 606, 728				1
7. 00 00700 (DPERATINO OF PLANT 0 2.377, 825 2.973, 825 2.973 228, 114 7. 0 0.00 00900 (HULSKERPEN ING 0 55, 210 05, 210 0, 380 86. 7. 638 8. 0 7. 7, 825 2.973, 825 2.973 228, 114 7. 6 8. 0 8. 0 0.00 01000 (DETARL 9. 00 1.00 88. 7. 0 77. 638 8. 0 1.0 9. 00 1.05 7. 0 77. 638 8. 0 1.0 <td></td> <td></td> <td>0</td> <td>126, 906</td> <td>-</td> <td>-</td> <td>-</td> <td>1</td>			0	126, 906	-	-	-	1
8. 00 00000 LAUMENT & LINEN SERVICE 0 55, 210 55, 270 0 10, 380 8 C 0. 00 00000 DICTARY 01000 DICTARY 0 77, 688 0 10. 00 01000 DICTARY 0 77, 688 0 77, 22, 99 10 11. 00 01000 DICTARY 0 77, 688 0 77, 22, 99 10 77, 688 0 12. 00 01000 DICTARY 0 77, 688 0 00, 215 9, 994 116, 37 11, 105, 079 77, 388 30 16, 353 16			0	0	0	0	-	
9.00 00000 HUSEKEEPING 0 85, 179 0 174, 852 174,			0					
10.00 01000 DITAL DITAL SEZ T74.852 T74.852 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
14.00 01400 [CNTRAL SERVICES & SUPPLY] 0 62, 264 52, 264 530 16, 359 14.2 INPATIENT ROUTINE SERVICE COST CENTERS 0 215 80, 216 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
15 00 0 1500 PHARMACY 0 80,215 9,984 118,273 15. 30 00 03000 ADULTS & PEDIATRICS 0 1,105,079 1,105,079 21,397 256,249 30. 10 00 3100 GUID INTENIS VECARE UNIT 0 285,428 6,948 83,526 31. 63.000 10 00 4100 SUBPROV DER - I PF 0 256,424 2,163 63,774 10. 64.00 64.00 64.00 64.00 64.00 64.00 64.01 64.01 64.01 64.00 64.01 64.01 64.01 64.01 64.01 64.01 64.01 64.01 64.01 64.01 64.01 64.01 64.01 64.01 65.00 51.0 51.00 51.00 51.00 51.00 51.00 51.00 51.00 55.00 54.0 64.41 9.31.4 10.1,420 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0 54.0			0					
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131.00 O3100 INTERSIVE CARE UNIT 0 285, 428 6, 948 83, 526 31.0 04.00 Oddoo SUBPROV DER - I PF 0 250, 442 250, 442 4, 163 63, 37.7 41.0 04.00 Oddoo SUBPROV DER - I PF 0	15.00		0	00,213	00, 213	7, 704	110, 273	15.00
40.00 [04000] SUBPROVI DER - 1 PF 0								1
41.00 0 0 100 Support 110 Support 110			0	285, 428				
42.00 04200 SUBPROVIDER 0			0	250 442	0	0	-	
ANCULLARY SERVICE COST CENTERS - - -			0					
50.0 0 00000 00000 00000 000000 000000000000000000000000000000000000	43.00		0	0	C	4, 412	47, 825	43.00
51:00 00 0 <td>50 00</td> <td></td> <td>0</td> <td>900, 206</td> <td>900, 206</td> <td>11 854</td> <td>278 567</td> <td>50.00</td>	50 00		0	900, 206	900, 206	11 854	278 567	50.00
57.00 05700 CT SCAN 0 33, 323 39, 323 30, 33, 63 66, 621 56, 00 60, 00 72, 60 73, 60 73, 80 66, 67 73, 81, 83, 63 66, 67 73, 80 73, 60 73, 60 73, 60 70, 00 70, 00 <td></td> <td></td> <td>0</td> <td>00,200</td> <td></td> <td></td> <td></td> <td>51.00</td>			0	00,200				51.00
58.00 05800 MACNETT C RESONANCE I MAGE (MR1) 0 46, 613 920 16, 221 58.0 59.00 05900 ARDIA CATHETER ZATION 0 131, 668 131, 668 2, 511 67, 412 59.0 60.01 06000 LABORATORY 0 0 0 3, 824 53, 144 60.0 60.01 06000 RADIATION ONCOLOGY 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
59.00 05900 CARDI AC CATHETERI ZATI ON 0 331, 688 131, 688 2, 511 67, 12 59.0 60.00 06000 LABORATORY 0 377, 531 87, 089 249, 034 60.0 60.01 06001 ONCOLOGY 0 0 0 0 0 0 60.0 60.02 06001 INTRAVENDUS THERAPY 0			0					
60. 00 00 00000 LABORATORY 0 377, 531 377, 531 377, 531 8, 089 249, 034 60.0 60. 01 060001 NCOLOGY 0			0					
60.02 CO O <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
64.00 0 <td></td> <td></td> <td>0</td> <td>0</td> <td>-</td> <td></td> <td></td> <td></td>			0	0	-			
65.00 06500 RESPIRATORY THERAPY 0 175, 113 175, 113 5, 091 75, 540 65. 05 66.00 06600 PHYSI CAL THERAPY 0 169, 496 169, 496 7, 630 78, 388 66. 06 67.00 06900 ELECTROCARDI OLOGY 0 0.78, 286 207, 826 207, 826 2, 183 39, 059 69, 00 0			0	0	-	-	-	
69.00 06900 ELECTROCARDI OLOGY 0 207,826 3,183 39,059 69.0 69.01 06901 CARDI AC REHAB 0 33,863 33,863 656 7,811 69.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 33,943 73.0 00100 ENERGENCY 0 127,899 1,731 35,618 90.0 91.0 92.0 92.00 92.00 92.01 085ERVATI 0N BEDS (NON-DI STINCT PART) 0 0 0 92.0 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.01 11.659,143 11.659,143 11.659,143 11.659,143 11.659,143 11.659,143 11.659,143 11.659,143 11.659,143 <td></td> <td></td> <td>0</td> <td>175, 113</td> <td>-</td> <td>-</td> <td>-</td> <td>•</td>			0	175, 113	-	-	-	•
69.01 6901 6901 CARDIAC REHAB 0 33,863 33,863 656 7,811 69.0 71.00 07100 WEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 0 0 0 0 72.00 0 0 0 73.00 0 0 0 0 73.00 0 0 0 0 72.00 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 72.00 0 0 0 72.00 0 0 0 73.00 73.00 0 0 0 0 72.00 0 0 0 0 0 0 92.00 0 0 0 0 0 0 92.00 92.00 92.00 92.00 0 0 0 0 0 92.00 92.00 92.00 0 0 0 0 92.00 92.00	66.00	06600 PHYSI CAL THERAPY	0		169, 496	7, 630	78, 388	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71.00 72.00 72.00 72.00 72.00 72.00 0 0 0 0 0 72.00 72.00 0 0 0 0 0 72.00 73.00			0					
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OUTPATI ENT SERVICE COST CENTERS O 90. 00 09000 CLINIC 0 127,899 127,899 1,131 35,618 90.0 91. 00 09100 EMERGENCY 0 289,269 289,269 31,097 213,001 91.0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 92.0 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 0 92.0 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 0 92.0 95. 00 OPSCOLABURSABLE COST CENTERS 0 108,433 108,433 3,988 42,881 95.0 113.00 INTEREST EXPENSE 0 116,659,143 11,659,143 202,920 2,695,386 118.00 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) 0 11,659,143 11,659,143 1,855 190.0 192.0 19200 PHYSI CLANS PRI VATE OFFI CES 0 0 0 1			0	-	-			72.00
90.00 09000 CLINIC 0 127, 899 1,731 35,618 90.0 91.00 09100 EMERGENCY 0 289,269 289,269 31,097 213,001 91.0 92.01 095EVATI ON BEDS (INON-DI STI NCT PART) 0 0 0 0 92.0 92.01 095EVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92.0 95.00 O9500 (AMBULANCE SERVICES 0 108,433 108,433 3,988 42,881 95.0 95.00 01300 INTEREST EXPENSE 0 114,659,143 116,59,143 202,920 2,695,386 118.0 113.00 INTEREST EXPENSE 111,659,143 11,659,143 202,920 2,695,386 118.0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 111,659,143 11,659,143 202,920 2,695,386 118.0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.0 192.02 192.02 192.02 192.02 192.02	73.00		0	0	C	0	333, 943	73.00
91.00 09100 EMREGENCY 0 289,269 289,269 31,097 213,001 91.00 92.01 9201 085ERVATION BEDS (DISTINCT PART) 0 0 0 0 92.01 9201 085ERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.01 0 0 0 0 0 92.01 0 0 0 0 0 92.01 0 0 0 0 0 0 0 0 92.01 0	90 00		0	127 800	127 800	1 121	35,618	
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OTHER REI MBURSABLE COST CENTERS 95.00 OPSOO[AMBULANCE SERCIAL PURPOSE COST CENTERS 95.00 113.00 ITAREE SERVICES 0 108, 433 108, 433 3, 988 42, 881 95.00 113.00 ITAREEST EXPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPECIAL PURPOSE 20, 920 2, 695, 386 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 11, 659, 143 11, 659, 143 202, 920 2, 695, 386 118.00 190.00 192000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 34, 725 34, 725 81 1, 855 190.0 0 0 192.02 192.01 PACT REV PHYSI CLANS 0 0 0 0 192.02 192.02 192.02 192.03 302GRAT BEGINNI NGS/MATERNAL 0 0 0 192.02 192.05 192.05 192.05 192.05 192.05 192.05 192.05 <t< td=""><td>92.00</td><td></td><td></td><td></td><td>C</td><td></td><td></td><td>92.00</td></t<>	92.00				C			92.00
95.00 09500 AMBULANCE SERVICES 0 108,433 108,433 3,988 42,881 95.0 SPECIAL PURPOSE COST CENTERS	92.01		0	0	C	0	0	92.01
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 113.00 INTEREST EXPENSE 0 11,659,143 11,659,143 202,920 2,695,386 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 11,659,143 11,659,143 202,920 2,695,386 118.00 118.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 34,725 34,725 81 1,855 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.01 192.01 19201 PACT REV PHYSI CI ANS 0 0 0 0 192.02 192.02 VI SI TOR MEALS 0 0 0 0 192.02 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.02 192.04 19204 LI FELI NE 0 0 0 0 11,671 192.02 192.05 19205 OWNED PROPERTI ES 0 0	95 00		0	108 433	108 433	3 988	42 881	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 11, 659, 143 11, 659, 143 202, 920 2, 695, 386 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 111, 659, 143 11, 659, 143 202, 920 2, 695, 386 118.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 34, 725 34, 725 81 1, 855 190.00 192.01 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.02 192.01 19201 PACT REV PHYSI CI ANS PHYSI CI ANS 0 0 0 192.02 192.02 192.03 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.02 192.03 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.03 192.04 192.04 192.05 192.05 192.05 0 0 0 0 192.05 192.05 192.05 192.05 192.06 192.04 192.04 192.04 192.04 192.04 192.04 <t< td=""><td></td><td></td><td></td><td></td><td>,</td><td></td><td>,</td><td></td></t<>					,		,	
NONRE I MBURSABLE COST CENTERS 0 34,725 34,725 81 1,855 190.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 34,725 34,725 81 1,855 190.00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.01 PACT REV PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.02 192.02 VI SI TOR MEALS 0 0 0 0 0 192.02 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 192.02 192.04 19204 LI FELI NE 0 0 0 0 0 192.02 192.05 0WRED PROPERTI ES 0 0 0 0 192.02 192.05 19206 UROLOGY 0 0 0 0 192.02 192.06 19206 UROLOGY 0 0 0 0 192.02			0	11 (50 110	44 (50 449	000.000	0 (05 00)	113.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 34,725 34,725 81 1,855 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.01 19201 PACT REV PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.02 192.02 19202 VI SI TOR MEALS 0 0 0 0 192.02 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.02 192.04 19204 LI FELI NE 0 0 0 0 192.02 192.05 19205 OWNED PROPERTI ES 0 0 0 192.02 192.06 19206 UROLOGY 0 0 0 192.02 192.07 19207 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.02 192.04 19204 LI FELI NE 0 0 0 0 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02	118.00		0	11, 659, 143	11, 659, 143	202, 920	2, 695, 386	118.00
192.01 PACT_REV_PHYSICIANS 0 0 1,827 20,582 192.02 192.02 19202 VI SI TOR_MEALS 0 0 0 0 192.02 192.03 19203 GREAT_BEGI NNI NGS/MATERNAL 0 0 0 327 3,025 192.02 192.04 19204 LI FELI NE 0 0 0 0 192.02 192.05 0WNED_PROPERTI ES 0 0 0 0 192.02 192.06 19206 UROLOGY 0 0 0 111, 671 192.02 192.07 19207 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.02 192.08 19211 PARI SH NURSI NG 0 0 0 192.02 192.09 19212 BI OTERRORI SM GRANT 0 0 0 192.02 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.02 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.02 192.10 <t< td=""><td>190.00</td><td></td><td>0</td><td>34, 725</td><td>34, 725</td><td>81</td><td>1, 855</td><td>190.00</td></t<>	190.00		0	34, 725	34, 725	81	1, 855	190.00
192.02 VI SI TOR MEALS 0 0 0 192.02 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 327 3,025 192.02 192.04 19204 LI FELI NE 0 0 0 0 192.02 192.05 19205 OWNED PROPERTI ES 0 0 0 11,671 192.02 192.06 19206 UROLOGY 0 0 0 11,671 192.02 192.07 19207 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.02 192.08 19211 PARI SH NURSI NG 0 0 0 192.02 192.09 19212 BI OTERRORI SM GRANT 0 0 0 192.02 192.09 19212 BI OTERRORI SM GRANT 0 0 0 192.02 192.10 19214 BREAST PUMPS 0 0 0 0 192.03			0	0				
192.03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 327 3,025 192.02 192.02 192.04 19204 LI FELI NE 0 0 0 0 192.02 192.05 19205 OWNED PROPERTI ES 0 0 0 11,671 192.02 192.06 19206 UROLOGY 0 0 0 3,185 40,206 192.02 192.07 19207 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 192.02 192.08 19211 PARI SH NURSI NG 0 0 0 192.02 192.12			0	0				1
192.04 19204 LI FELI NE 0 0 0 192.05 192.05 19205 OWNED PROPERTI ES 0 0 0 11, 671 192.05 192.06 19206 UROLOGY 0 0 0 3, 185 40, 206 192.05 192.07 19207 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.07 192.08 19211 PARI SH NURSI NG 0 0 0 192.07 19212 BI OTERRORI SM GRANT 0 0 0 192.07 192.10 19214 BREAST PUMPS 0 0 0 0 192.07			0	0	-	-		
192.06 192.06 UROLOGY 0 0 3, 185 40, 206 192.07 192.07 19207 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.07 192.08 19211 PARI SH NURSI NG 0 0 0 222 2, 468 192.07 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.07 192.10 19214 BREAST PUMPS 0 0 0 0 192.17			0	0	-			
192.07 19207 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.02 192.08 19211 PARI SH NURSI NG 0 0 0 222 2,468 192.02 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.02 192.10 19214 BREAST PUMPS 0 0 0 0 192.12			0	0				
192.08 19211 PARI SH NURSI NG 0 0 222 2,468 192.02 192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.02 192.10 19214 BREAST PUMPS 0 0 0 0 192.12			0	0	-			
192.09 19212 BI OTERRORI SM GRANT 0 0 0 0 192.00 192.10 19214 BREAST PUMPS 0 0 0 0 192.10			0	0	C	-		
	192.09	19212 BI OTERRORI SM GRANT	0	0	-	0	0	192.09
iyz. i ji yzusimuch emerkuency physicians i UI UI UI UI OI OI 01192. 1			0	0	-			
192. 12 19209 LUNG CENTER 0 0 0 2, 417 25, 505 192. 1			0	0	-	-		
192. 13 19213 MGH EXPRESS 0 0 0 3, 835 42, 560 192. 1			0	0	-			
192.14 19210 MGH PHYS PRACT MGMT 0 0 5,042 64,548 192.1			0	0	C			
192.15 MGH MARI ON SURGEONS 0 0 5,700 59,564 192.1 192.16 19216 MGH MED ONC 0 0 0 4,422 45,405 192.1			0	0	0			
192. 10 192.10 MGH MGH MGH MCH WED UNC 0 0 4, 422 43, 403 192. 1 192. 17 19217 MGH FMC SOUTH 0 0 0 6, 210 76, 162 192. 1			0	0	-			
		19218 MGH FAIRM MED ASSOC	0	0				192. 18

Health Finan	ncial Systems	MARION GENER	AL HOSPI TAL			In Lie	u of Form CMS-:	2552-10
ALLOCATION (OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0011	Peri Fror To	iod: m 07/01/2020 06/30/2021	Worksheet B Part II Date/Time Pre 11/29/2021 7:	pared: 49 am
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal		EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A		4.00	5.00	
193. 0019300193. 0119301193. 0219302193. 0319303193. 0419304193. 0519305193. 0619307193. 0719307193. 0819308193. 0919307193. 0919309193. 1019310193. 1119311193. 1219315193. 1619315193. 1619315193. 1619316194. 0107950194. 0207951194. 0307952194. 0407955194. 0707956194. 0807977194. 0907958194. 1007961194. 1307965194. 1407964194. 1507965194. 1607962194. 1807962194. 1907968194. 1907968194. 1907968194. 1907968194. 1907968194. 1907968194. 1907968194. 1907968194. 1907968194. 2007970	MGH RIVER VIEW BLDG MGH NEONATOLOGY MGH WOUND CARE HEART FAILURE CLINIC MOW MENTAL HEALTH ADVERTISING MGH WORK SOLUTIONS MGH TAYLOR UNIVERSITY OPIOID IMPL GRANT ASTHMA GRANT MGH SMMP BLDG ASTHMA GRANT MGH 106 LYONS BLDG MGH AMBUCARE BLDG MGH 106 LYONS BLDG FAIRMOUNT GAS CITY LYONS WABASH TOBACCO GRANT HRSA NETWORK DEV PLANNING HRSA OFIOID PLANNING ECHO GRANT RURAL QI GRANT				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 3,426 0 3,443 2,395 10,186 9,830 635 1,697 900 806 228 0 0 0 7,523 0 0 0 82 130 0 82 130 0 82 130 0 82 130 0 0 82 130 0 0 18 10 10 10 10 10 10 10 10 10 10	38, 296 0 37, 341 29, 248 104, 407 112, 679 7, 708 22, 803 9, 821 10, 988 2, 770 0 0 91, 473 0 24, 737 841 1, 853 28 8, 588 8, 588 105 0 0 0 8, 110 27, 235 28 8, 588 8, 508 105 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	193. 02 193. 03 193. 04 193. 05 193. 06 193. 07 193. 08 193. 09 193. 10 193. 12 193. 15 193. 16 193. 18 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 07 194. 10 194. 12 194. 14 194. 12 194. 14 194. 15 194. 14 194. 15 194. 14 194. 15 194. 16 194. 17 194. 18 194. 19 194. 20
194. 22 07972 194. 23 07973 194. 24 07974	MGH MGH ORTHO MGH BELLA BLDG DIABETES GRANT MGH NORTHWOOD BLDG MGH MGH ORTHO Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)		0 0 0 0 11, 693, 868	11, 693, 8	0 0 0 0 0 0 368	0 0 0 1, 319 0 283, 076	0 112 0 14, 149	194. 21 194. 22 194. 23 194. 24 194. 25 200. 00 201. 00 202. 00

Heal th	Financial Systems	MARION GENERAL	- HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 07/01/2020	Worksheet B Part II	
					06/30/2021	Date/Time Pre 11/29/2021 7:	pared:
	Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
		REPAI RS 6.00	6. 01	6.02	PLANT 7.00	LINEN SERVICE 8.00	
	GENERAL SERVICE COST CENTERS			0.02		0100	
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS	0					6.00
6.01	00601 CAFETERI A	0	175, 580	470 (()			6.01
6.02 7.00	00602 CAFETERIA 00700 OPERATION OF PLANT	0	173, 666 0	173, 666 4, 966			6. 02 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	4, 700		92, 822	•
9.00	00900 HOUSEKEEPI NG	0	0	0	42, 014	0	
10.00		0	0	43	86, 245	0	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	0	3, 813 1, 037	8, 970 30, 712	0 14	13.00 14.00
15.00	01500 PHARMACY	0	0	9, 087	39, 566	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	- -	-1				
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0	24, 353 7, 691	545, 075 140, 786	21, 868 5, 168	•
40.00	04000 SUBPROVIDER - IPF	0	0	7, 041	140, 780	5, 108	
41.00	04100 SUBPROVI DER – I RF	0	0	4, 816	123, 530	2, 122	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	4, 788	0	0	43.00
50.00	05000 OPERATING ROOM	0	0	14, 555	444, 023	11, 009	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	0	11, 763 2, 577	266, 597 19, 396	5, 812 3, 249	•
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 250		0,247	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	2, 886		877	59.00
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY	0	0	11, 972 0	186, 216	0 352	
60. 01 60. 02	06002 RADIATION ONCOLOGY	0	0	0	0	352	60.01
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	5, 167	86, 374	624	65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	0	3, 719 4, 491	83, 603 102, 510	2, 290 815	•
69.01	06901 CARDI AC REHAB	0	0	718		010	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	•
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	/ 3.00
90.00	09000 CLI NI C	0	0	1, 544		197	90.00
91.00	09100 EMERGENCY	0	0	20, 838	142, 681	35, 134	
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.00 92.01
	OTHER REIMBURSABLE COST CENTERS		-1		-	-	
95.00	09500 AMBULANCE SERVICES	0	0	6, 324	53, 484	2, 914	95.00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
118.00		0	173, 666	148, 398	2, 596, 750	92, 445	118.00
	NONREI MBURSABLE COST CENTERS				47.400		1.00.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	17, 128		190. 00 192. 00
	19201 PACT REV PHYSICIANS	0	0	0	0		192.00
	19202 VISITOR MEALS	0	1, 914	0	0		192. 02
	3 19203 GREAT BEGI NNI NGS/MATERNAL 19204 LI FELI NE	0	0	0	0		192. 03 192. 04
	19205 OWNED PROPERTIES	0	0	0	0		192.04
	19206 UROLOGY	0	0	3, 157	0		192.06
	19207 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.07
	19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT	0	0	298 0	0		192. 08 192. 09
	19214 BREAST PUMPS	0	0	0	0		192.10
192 . 11	19208 MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192. 11
	2 19209 LUNG CENTER 3 19213 MGH EXPRESS	0	0	1, 491	0		192. 12 192. 13
	19213 MGH EXPRESS 19210 MGH PHYS PRACT MGMT	0	0	0 8, 794	0		192.13
192.15	19215 MGH MARION SURGEONS	0	Ō	3, 900		0	192. 15
	19216 MGH MGH MED ONC	0	0	0	0		192.16
	19217 MGH FMC SOUTH 19218 MGH FAIRM MED ASSOC	0	0	0	0		192. 17 192. 18
	19219 MGH FMC MARI ON	0	0	3, 748	0		192.10
	19300 NONPAID WORKERS	0	О	0	0		193.00
	19301 MGH FMC NORTHWOOD 19302 MGH FMC GAS CITY	0	0	0	0		193. 01 193. 02
173.02		1 0	U	0	U U	00	1173.02

Health Financial Systems	MARION GENERA	HOSPI TAI		Inlie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0011 P	eri od:	Worksheet B	
RECORTION OF GRITINE REEATED COSTS				rom 07/01/2020		
				o 06/30/2021	Date/Time Pre	pared:
					11/29/2021 7:	49 am
Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
	REPAI RS			PLANT	LINEN SERVICE	
	6.00	6.01	6. 02	7.00	8.00	
193. 03 19303 MGH HOSPI TALI STS	0	0	0	0	0	193.03
193.04 19304 MGH MAR FAM PRACT	0	0	0	0	79	193.04
193.05 19305 MGH FMC SWAYZEE	0	0	0	0	0	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	1, 832	0	2	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	841	0	0	193. 07
193.08 19308 MGH FMC CONVERSE	0	0	0	0	8	193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	39	193.09
193.1019310 MGH MGH WOMENS CTR	0	0	0	0	0	193. 10
193.11 19311 MGH MGH PSYCHLATRY	0	0	0	0	0	193. 11
193. 12 19312 OB/GYN	0	0	0	0	0	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193. 15
193. 16 19316 MGH NEONATOLOGY	0	0	o	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	0	0	0		194.03
194. 04 07953 MGH WORK SOLUTI ONS	0	0	0	0		194.04
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0	0			194.05
194. 06 07955 OPI OI D I MPL GRANT	0	0	544	-		194.06
194. 07 07956 ASTHMA GRANT	0	0	12			194.00
194. 08 07957 MGH SMMP BLDG	0	0	0			194.08
194. 09 07958 MGH AMBUCARE BLDG	0	0	0	-		194.00
194. 10 07959 MGH 106 LYONS BLDG	0	0		0		194.10
194. 11 07960 FAI RMOUNT	0	0	0	-		194.10
194. 12 07961 GAS_CITY	0	0	0	0		194.12
194. 13 07969 LYONS	0	0	0	-		194.12
194. 14 07964 WABASH	0	0	0	-		194.13
194. 15 07965 TOBACCO GRANT	0	0	270	-		194.14
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0	2/0			194.15
194. 17 07967 HRSA OPIOID PLANNING	0	0		-		194.10
194. 18 07962 ECHO GRANT	0	0	21	0		194.17
194. 19 07968 RURAL QI GRANT	0	0	360	•		194. 18
194. 20 07930 MGH DI ABETES GRANT	0	0	300			194. 19
194. 20 07970 MGH DIABETES GRANT 194. 21 07971 MGH MGH ORTHO	0	0		0		194. 20
	0	0		0		
194. 22 07972 MGH BELLA BLDG	0	0		0		194.22
	0	0		0		194.23
194. 24 07974 MGH NORTHWOOD BLDG	0	0	0	0		194.24
194. 25 07975 MGH MGH ORTHO	0	0	0	0	0	194.25
200.00 Cross Foot Adjustments		~	_	_	_	200.00
201.00 Negative Cost Centers	0	175 500	172 ((0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	175, 580	173, 666	2, 613, 878	92, 822	202.00

Health Financial Systems	MARION GENERA	I HOSPITAL		Inlieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	MART ON GENERAL	Provider C		eri od:	Worksheet B	2002 10
			Fr To	om 07/01/2020 06/30/2021	Part II Date/Time Pre	pared:
	1				11/29/2021 7:	
Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	
				SUPPLY		
	9.00	10.00	13.00	14.00	15.00	
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINI STRATI VE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
6. 01 00601 CAFETERI A 6. 02 00602 CAFETERI A						6. 01 6. 02
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG	204, 821	007 404				9.00
10. 00 01000 DI ETARY 13. 00 01300 NURSI NG ADMI NI STRATI ON	2, 934 917	287, 136 0	74, 783			10.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	4, 584	0	0	115, 500		14.00
15. 00 01500 PHARMACY	2, 567	0	0	0	259, 692	15.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F4 07/	1/2 050	17 001	10 705		20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	54, 276 10, 269	162, 050 29, 406		12, 705 3, 465	0	30.00 31.00
40. 00 04000 SUBPROVI DER – I PF	0	0	0,002	0, 100	0	40.00
41. 00 04100 SUBPROVI DER – I RF	8, 802	27, 606	3, 558	1, 155	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	3, 537	0	0	43.00
50. 00 05000 OPERATI NG ROOM	27, 138	0	6, 886	15, 015	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	11,644	0	0	2, 310	0	54.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	642	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 667	0	2, 132	4, 620	0	59.00
60. 00 06000 LABORATORY	10, 269	0	0	6, 930	0	60.00
60. 01 06001 0NC0L0GY 60. 02 06002 RADI ATI 0N ONC0L0GY	0	0	0	0	0	60. 01 60. 02
64. 00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	7, 701	0	3, 817	2, 310	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	2, 747	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	4, 951 5, 501	0	3, 318 531	3, 465 0	0	69.00 69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 501	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	259, 692	73.00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	3, 667	0	1, 140	0	0	90.00
91. 00 09100 EMERGENCY	41,074	4, 208		5, 775	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						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	1, 284	0	4, 672	1, 155	0	95.00
SPECIAL PURPOSE COST CENTERS			.,	.,	-	
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	201, 887	223, 270	71, 405	58, 905	259, 692	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	367	0	0	0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
192. 01 19201 PACT REV PHYSI CLANS	0	0	0	0		192.01
192. 02 19202 VI SI TOR MEALS 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	0	0	0 260	0		192. 02 192. 03
192. 04 19204 LI FELI NE	0	0	0	0		192.03
192.05 19205 OWNED PROPERTIES	0	0	0	0	0	192.05
192. 06 19206 UROLOGY	0	0	0	4, 620		192.06
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19211 PARI SH NURSI NG	733 367	0	0	0		192. 07 192. 08
192. 09 19212 BI OTERRORI SM GRANT	0	0	0	0		192.00
192.10 19214 BREAST PUMPS	0	0	0	0	0	192. 10
192. 11 19208 MGH EMERGENCY PHYSICIANS	0	0	0	0		192.11
192.12 19209 LUNG CENTER 192.13 19213 MGH EXPRESS	0	0	0 3, 118	0 2, 310		192. 12 192. 13
192. 14 19210 MGH PHYS PRACT MGMT	1, 467	0	0	2, 3,0		192.13
192.15 19215 MGH MARI ON SURGEONS	0	0	0	6, 930	0	192. 15
192.16 19216 MGH MGH MED ONC	0	0	0	0		192. 16 192. 17
192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC	0	0		4, 620 0		192.17
192.19 19219 MGH FMC MARION	0	0	0	3, 465	0	192. 19
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
193.01 19301 MGH FMC NORTHWOOD	0	0	0	1, 155	0	193.01

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II	epared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI (CENTRAL DN SERVICES & SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193.02 19302 MGH FMC GAS CITY	0	0		0 1, 155	C	193.02
193. 03 19303 MGH HOSPI TALI STS	0	0		0 0	C	193.03
193.04 19304 MGH MAR FAM PRACT	0	0		0 6, 930	C	193.04
193.05 19305 MGH FMC SWAYZEE	0	0		0 1, 155	C	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0		0 1, 155	C	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	C	193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 1, 155	C	193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 2, 310	C	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0	C	193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0 0	C	193.11
193. 12 19312 OB/GYN	0	0		0 17, 325	C	193. 12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0	C	193. 15
193.16 19316 MGH NEONATOLOGY	0	0		0 0	C	193.16
193.18 19318 MGH WOUND CARE	0	0		0 0	C	193. 18
194.0007963 HEART FAILURE CLINIC	0	0		0 0	C	194.00
194.0107950 MOW	0	34, 567		0 0	C	194.01
194.0207951 MENTAL HEALTH	0	29, 299		0 0	C	194. 02
194. 03 07952 ADVERTI SI NG	0	0		0 0		194.03
194.0407953 MGH WORK SOLUTIONS	0	0		0 2, 310	C	194.04
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0		0 0	C	194.05
194.06079550PIOLD IMPL GRANT	0	0		0 0	C	194.06
194.07 07956 ASTHMA_GRANT	0	0		0 0	C	194. 07
194.08 07957 MGH_SMMPBLDG	0	0		0 0		194.08
194.0907958MGH 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	C	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	0		0 0		194. 15
194.1607966 HRSA NETWORK DEV PLANNING	0	0		0 0		194.16
194. 17 07967 HRSA OPI 0I D PLANNI NG	0	0		0 0		194. 17
194.1807962ECH0 GRANT	0	0		0 0		194. 18
194. 19 07968 RURAL QI GRANT	0	0		0 0		194. 19
194.2007970 MGH DIABETES GRANT	0	0		0 0		194. 20
194.21 07971 MGH MGH ORTHO	0	0		0 0		194. 21
194.2207972 MGH BELLA BLDG	0	0		0 0		194. 22
194. 23 07973 DI ABETES GRANT	0	0		0 0		194.23
194. 24 07974 MGH NORTHWOOD BLDG	0	0		0 0		194.24
194. 25 07975 MGH MGH ORTHO	0	0		0 0	C C	194.25
200.00 Cross Foot Adjustments		_		-	-	200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	204, 821	287, 136	74, 78	33 115, 500	259, 692	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	MARION GENER	AL HOSPITAL Provider CC	N· 15-0011	In Lie Period:	u of Form CMS-2552-10 Worksheet B
ALLOCA	THON OF CALLER RELATED COSTS				From 07/01/2020 To 06/30/2021	Part II Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		11/29/2021 7:49 am
			Residents Cost & Post			
			Stepdown Adjustments			
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00	1	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00 5.00	00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL					4.00
6.00	00600 MAI NTENANCE & REPAI RS					6.00
6.01						6.01
6. 02 7. 00	00602 CAFETERIA 00700 OPERATION OF PLANT					6. 02 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00 15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>			15.00
	03000 ADULTS & PEDIATRICS	2, 221, 043	1	2, 221, 04		30.00
	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	578, 369 0	0	578, 36	9	31.00
41.00	04100 SUBPROVI DER – I RF	489, 571	1	489, 57	1	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 60, 562	0	60, 56		42.00
43.00	ANCI LLARY SERVI CE COST CENTERS	00, 302		00, 30		43.00
50.00 51.00	05000 OPERATING ROOM	1, 709, 253 0	0	1, 709, 25	3	50.00 51.00
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	1,009,354	1	1, 009, 35	5	54.00
57.00	05700 CT SCAN	98, 117		98, 11		57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	87, 996 280, 748	1	87, 99 280, 74		58.00 59.00
60.00	06000 LABORATORY	850, 041	0	850, 04	1	60.00
60. 01 60. 02	06001 ONCOLOGY 06002 RADI ATI ON ONCOLOGY	57, 370 0	0	57, 37		60. 01 60. 02
64. 00	06400 I NTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	361, 737		361, 73		65.00
66.00 69.00	06900 ELECTROCARDI OLOGY	347, 873 369, 618		347, 87 369, 61		66. 00 69. 00
69.01	06901 CARDI AC REHAB	65, 783	0	65, 78		69.01
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	593, 635	0	593, 63	5	73.00
90 00	OUTPATIENT SERVICE COST CENTERS	234, 282	0	234, 28	2	90.00
91.00	09100 EMERGENCY	798, 471	, v	798, 47		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		D	92.00 92.01
92.01	OTHER REIMBURSABLE COST CENTERS	0	<u> </u>		5	92.01
95.00	09500 AMBULANCE SERVICES	225, 135	0	225, 13	5	95.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE					113.00
118.00		10, 438, 958	0	10, 438, 95	8	118.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	54, 156	ol	54, 15	6	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		C	192.00
	19201 PACT REV PHYSICIANS 19202 VISITOR MEALS	22, 409 1, 914		22, 40 1, 91		192. 01 192. 02
192.03	19203 GREAT BEGI NNI NGS/MATERNAL	3, 612		3, 61		192. 03
	19204 LIFELINE 19205 OWNED PROPERTIES	0 11 671	-			192. 04 192. 05
192.06	19206 UROLOGY	11, 671 51, 168	1	11, 67 51, 16		192.05
	19207 PHYSI CLANS' PRI VATE OFFI CES	733		73		192.07
	19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT	3, 355 0	0	3, 35	5	192. 08 192. 09
192.10	19214 BREAST PUMPS	0	o		p	192. 10
	19208 MGH EMERGENCY PHYSICIANS 19209 LUNG CENTER	0 29, 413	0	29, 41	3	192. 11 192. 12
192.13	19213 MGH EXPRESS	51, 945		51, 94		192. 13
	19210 MGH PHYS PRACT MGMT	79, 851	1	79, 85		192.14
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	76, 094 49, 827		76, 09 49, 82		192. 15 192. 16
192.17	19217 MGH FMC SOUTH	87, 030	0	87, 03	С	192. 17
	19218 MGH FAIRM MED ASSOC 19219 MGH FMC MARION	14, 675 48, 938	1 1	14, 67 48, 93		192. 18 192. 19
. / 2. 17		,0,730	י ט <u>י</u>	+0, 75	-1	11/2.17

Health Financial Systems	MARION GENERA	AL HOSPI TAL		In Lieu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: Worksheet B	
				From 07/01/2020 Part II To 06/30/2021 Date/Time Pre	narod
				11/29/2021 7:	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
	24.00	Adjustments 25.00	26.00		
193. 00 19300 NONPAI D WORKERS	24.00	23.00		0	193.00
193. 01 19301 MGH FMC NORTHWOOD	41, 957	0		-	193.01
193.02 19302 MGH FMC GAS CITY	32, 854	0	32, 85		193.02
193. 03 19303 MGH HOSPI TALI STS	114, 593	0	114, 59		193. 03
193.04 19304 MGH MAR FAM PRACT	129, 518	0	129, 51	8	193. 04
193.05 19305 MGH FMC SWAYZEE	9, 498	0	9, 49		193. 05
193.06 19306 MGH PEDIATRIC CTR	27, 489	0	27, 48		193.06
193.07 19307 MGH SPECIALTY PHYS	11, 562	0	11, 56		193.07
193. 08 19308 MGH FMC CONVERSE	12,957	0	12, 95		193.08
193.09 19309 MGH UPLAND HEALTH 193.10 19310 MGH MGH WOMENS CTR	5, 347	0	5, 34	0	193. 09 193. 10
193. 11 19311 MGH MGH PSYCHIATRY	0	0		0	193.10
193. 12 19312 OB/GYN	116, 321	0	116, 32	0	193.12
193. 15 19315 MGH RIVER VIEW BLDG	0	0	110, 02	0	193.15
193. 16 19316 MGH NEONATOLOGY	24, 737	0	24, 73	57	193.16
193.18 19318 MGH WOUND CARE	923	0	92		193. 18
194.0007963 HEART FAILURE CLINIC	1, 983	0	1, 98	3	194.00
194.0107950 MOW	34, 567	0	34, 56		194.01
194.0207951 MENTAL HEALTH	29, 299	0	29, 29		194. 02
194. 03 07952 ADVERTI SI NG	8, 799	0	8, 79		194.03
194. 04 07953 MGH WORK SOLUTIONS	31, 452	0	31, 45		194.04
194. 05 07954 MGH TAYLOR UNIVERSITY 194. 06 07955 0PI 0I D I MPL GRANT	29 9, 360	0	9, 36	29	194.05 194.06
194. 07/07956 ASTHMA GRANT	127	0	9, 30		194.00
194. 08 07957 MGH SMMP BLDG	0	0		0	194.08
194. 09 07958 MGH AMBUCARE BLDG	0	0		0	194.09
194.1007959 MGH 106 LYONS BLDG	0	0		0	194.10
194. 11 07960 FAI RMOUNT	0	0		0	194.11
194. 12 07961 GAS CLTY	0	0		0	194. 12
194. 13 07969 LYONS	0	0		0	194.13
194. 14 07964 WABASH	0	0		0	194.14
194. 15 07965 TOBACCO GRANT	2, 193	0	2, 19		194.15
194. 16 07966 HRSA NETWORK DEV PLANNING 194. 17 07967 HRSA OPI OLD PLANNING	0	0		0	194. 16 194. 17
194. 18 07962 ECHO GRANT	1, 500	0	1, 50	-	194.17
194. 19 07968 RURAL QI GRANT	5, 474	0	5, 47		194.10
194. 20 07970 MGH DI ABETES GRANT	0	0		0	194.20
194.2107971 MGH MGH ORTHO	0	0		0	194. 21
194.2207972 MGH BELLA BLDG	0	0		0	194. 22
194. 23 07973 DI ABETES GRANT	112	0	11	2	194. 23
194.24 07974 MGH NORTHWOOD BLDG	0	0		0	194. 24
194. 25 07975 MGH MGH ORTHO	15, 468	0	15, 46		194.25
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)		0	11 402 04	0	201.00 202.00
202.00 TOTAL (sum lines 118 through 201)	11, 693, 868	I U	11, 693, 86		202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MARION GENERA		CN: 15-0011 F	In Lie eriod:	u of Form CMS-: Worksheet B-1	
				F	rom 07/01/2020 o 06/30/2021	Date/Time Pre	
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)		ADMI NI STRATI VE & GENERAL (ACCUM. COST)	11/29/2021 7:	
		1.00	4.00	5A	5.00	6. 00	
	GENERAL SERVICE COST CENTERS	447.550			1		1 00
4.00 5.00 6.01 6.01 6.02 7.00 8.00 9.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 006001 CAFETERIA 00601 CAFETERIA 00700 OPERATION OF PLANT 00700 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	447, 552 10, 834 138, 038 0 4, 857 0 91, 005 2, 113 3, 260 6, 692	75, 136, 416 15, 180, 731 C C 789, 094 C 19, 403	-33, 118, 069	0 1, 747, 286 0 8, 188, 736 372, 634 2, 786, 674	298, 680 4, 857 0 91, 005 2, 113 3, 260	6. 01 6. 02 7. 00 8. 00 9. 00
	01300 NURSING ADMINISTRATION	696	1, 069, 228				
	01400 CENTRAL SERVICES & SUPPLY	2, 383	140, 717 2, 650, 400				
30. 00 31. 00 40. 00 41. 00 42. 00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 070 42, 294 10, 924 0 9, 585 0 0 0	2, 650, 400 5, 680, 063 1, 844, 520 0 1, 105, 209 0 1, 171, 198		9, 198, 723 2, 998, 372 0 2, 275, 081 0	3, 070 42, 294 10, 924 0 9, 585 0 0	30. 00 31. 00 40. 00 41. 00 42. 00
50.00	05000 OPERATING ROOM	34, 453	3, 146, 823		9, 999, 891	34, 453	50.00
54.00 57.00 58.00 59.00 60.00 60.01 60.02	05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 ONCOLOGY 06002 RADIATION ONCOLOGY 06400 INTRAVENOUS THERAPY	0 20, 686 1, 505 1, 784 5, 040 14, 449 0 0	2, 472, 599 503, 691 244, 355 666, 665 2, 147, 253 1, 015, 079		0 5, 794, 584 1, 114, 024 582, 294 2, 419, 942 8, 939, 720 1, 909, 551	0 20, 686 1, 505 1, 784 5, 040	51.00 54.00 57.00 58.00 59.00 60.00
65.00 66.00 69.00 69.01 71.00 72.00 73.00	06500 RESPI RATORY THERAPY 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	6, 702 6, 487 7, 954 1, 296 0 0 0	1, 351, 479 2, 025, 589 844, 899 174, 265 0 0 0		1, 402, 115 280, 404 0 0	6, 702 6, 487 7, 954 1, 296 0 0	65.00 66.00 69.00 69.01 71.00 72.00
	OUTPATIENT SERVICE COST CENTERS	4, 895	300, 367	' C	1, 278, 593	4, 895	90.00
91.00 92.00 92.01	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	4, 073 11, 071 0	8, 255, 125	i C	7, 646, 244		91.00 92.00
	09500 AMBULANCE SERVICES	4, 150	1, 058, 632	2 C	1, 539, 321	4, 150	95.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	446, 223	53, 857, 377	-33, 118, 069	96, 757, 309	297, 351	113. 00 118. 00
192.00 192.01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PACT REV PHYSICIANS 19202 VISITOR MEALS	1, 329 0 0 0	21, 538 C 485, 128 C) C	0 738, 844	0 0	190. 00 192. 00 192. 01 192. 02
192.04 192.05	19203 GREAT BEGI NNI NGS/MATERNAL 19204 LI FELI NE 19205 OWNED PROPERTI ES	000000000000000000000000000000000000000	86, 844 C C		0 418, 960	0 0	192. 03 192. 04 192. 05
192. 07 192. 08 192. 09 192. 10	19206 UROLOGY 19207 PHYSI CI ANS' PRI VATE OFFI CES 19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT 19214 BREAST PUMPS 19208 MGH EMERGENCY PHYSI CI ANS		845, 619 C 58, 811 C C C C) C	0 88, 596 0 0	0 0 0 0	192. 06 192. 07 192. 08 192. 09 192. 10 192. 11
192. 12 192. 13 192. 14 192. 15 192. 16	19209 LUNG CENTER 19213 MGH EXPRESS 19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH		641, 720 1, 018, 019 1, 338, 512 1, 513, 092 1, 173, 980 1, 648, 565		1, 527, 804 2, 317, 129 2, 138, 192 1, 629, 941	0 0 0 0 0	192. 12 192. 13 192. 14 192. 15 192. 16 192. 17

OST ALLOCATION - STATISTICAL BASI	S	MARION GENERA	Provider C		In Lie Period:	Worksheet B-1	
					rom 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:	
		CAPI TAL	I				
		RELATED COSTS					
Cost Center Descriptio	n	NEW BLDG &	EMPLOYEE	Reconciliatior	ADMI NI STRATI VE		
		FIXT	BENEFITS		& GENERAL	REPAI RS	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1.00	SALARI ES)		F 00	(00	
92. 18 19218 MGH FAIRM MED ASSOC		1.00	4.00	5A (5.00 485.785	6.00	192.
92. 19 19219 MGH FMC MARION		0	909, 430				192.
93. 00 19300 NONPAID WORKERS		0	909, 4 30 0				193.
93. 01 19301 MGH FMC NORTHWOOD		0	913, 931		-		193.
93. 02 19302 MGH FMC GAS CITY		0	635, 721				193.
93. 03 19303 MGH HOSPI TALI STS		0	2, 703, 952		.,		193.
93. 04 19304 MGH MAR FAM PRACT		0	2,609,563				193.
93. 05 19305 MGH FMC SWAYZEE		0	168, 666	1			193.
93. 06 19306 MGH PEDIATRIC CTR		0	450, 581		,		193.
93.07 19307 MGH SPECIALTY PHYS		0	238, 860				193.
93. 08 19308 MGH FMC CONVERSE		0	214, 026				193.
93.09 19309 MGH UPLAND HEALTH		0	60, 566	1			193.
93.1019310 MGH MGH WOMENS CTR		0	0				193.
93.11 19311 MGH MGH PSYCHLATRY		0	0	0	0 0	0	193.
93. 12 19312 OB/GYN		0	1, 997, 022	0	3, 283, 669	0	193.
93.15 19315 MGH RIVER VIEW BLDG		0	0	(0 0	0	193.
93.16 19316 MGH NEONATOLOGY		0	0	(888, 000	0	193.
93.18 19318 MGH WOUND CARE		0	21, 787	((30, 183	0	193.
4.0007963 HEART FAILURE CLINIC		0	34, 481	(66, 520	0	194
94.0107950 MOW		0	0	0 0	0 0	0	194
94.0207951 MENTAL HEALTH		0	0	0	0 0	0	194.
94. 03 07952 ADVERTI SI NG		0	182, 948	(291, 122	0	194.
94.0407953 MGH WORK SOLUTIONS		0	503, 567	(977, 665	0	194.
94.0507954 MGH TAYLOR UNIVERSITY		0	153	(998	0	194.
94.06079550PIOID IMPL GRANT		0	60, 565				194.
94.0707956 ASTHMA GRANT		0	2, 697				194.
94.0807957 MGH SMMP BLDG		0	0				194.
94.0907958 MGH AMBUCARE BLDG		0	0		-		194.
94.1007959 MGH 106 LYONS BLDG		0	0				194.
94. 11 07960 FAI RMOUNT		0	0	(-		194
94. 12 07961 GAS CITY		0	0	(-		194
94. 13 07969 LYONS		0	0		-		194
94. 14 07964 WABASH		0	0		-		194
24. 15 07965 TOBACCO GRANT		0	42, 338				194
24. 16 07966 HRSA NETWORK DEV PLANN	II NG	0	0		-		194
94.17 07967 HRSA OPIOID PLANNING 94.18 07962 ECHO GRANT		0	3, 153		-		194 194
24. 19 07968 RURAL QI GRANT		0	40, 459				194
24. 20 07970 MGH DI ABETES GRANT		0	40, 439				194
24. 21 07971 MGH MGH OTABETES GRANT		0	0		-		194
24. 22 07972 MGH BELLA BLDG		0	0				194
24. 23 07973 DI ABETES GRANT		0	0		-		194
94. 24 07974 MGH NORTHWOOD BLDG		0	0				194
94. 25 07975 MGH MGH ORTHO		0	350, 225		507, 916		194
00.00 Cross Foot Adjustments		, i i i i i i i i i i i i i i i i i i i	0007 220			, i i i i i i i i i i i i i i i i i i i	200
01.00 Negative Cost Centers							201
02.00 Cost to be allocated (per Wkst. B.	11, 693, 868	16, 305, 792		33, 118, 069	0	202
Part I)	mot 0,	, 0, 0, 000					- 22
03.00 Unit cost multiplier (Wkst. B, Part I)	26. 128512	0. 217016		0. 251798	0.000000	203
04.00 Cost to be allocated (283, 076		3, 663, 955		204.
Part II)			, ,,,,,				1
05.00 Unit cost multiplier (Wkst. B, Part		0. 003767		0.027857	0. 000000	205.
06.00 NAHE adjustment amount (per Wkst. B-2)	to be allocated						206
07.00 NAHE unit cost multipl	ier (Wkst. D,						207
Parts III and IV)		1 1		1	1		1

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENERA	L HOSPITAL Provider CO	CN: 15 0011 D	In Lie eriod:	u of Form CMS-: Worksheet B-1	
COST ALLOCATION - STATISTICAL DASIS		Provider co		rom 07/01/2020	Date/Time Pre	pared:
Cost Center Description	CAFETERI A (MEALS SERVED)	CAFETERI A (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	11/29/2021 7: HOUSEKEEPI NG (HOURS OF SERVI CE)	
	6.01	6.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS	1 1					1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 6.01 00601 CAFETERI A 6.02 00602 CAFETERI A 7.00 007000 OPERATION OF PLANT	226, 446 223, 977 0	1, 254, 082 35, 864				1.00 4.00 5.00 6.00 6.01 6.02 7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY		0 0 313 27, 536 7, 485 65, 617	696	658, 013 0 0 100 0	58, 084 832 260 1, 300 728	10. 00 13. 00 14. 00
INPATIENT ROUTINE SERVICE COST CENTERS		00/01/	6, 6, 6		120	10100
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS		175, 856 55, 540 0 34, 778 0 34, 576	10, 924 0 9, 585 0	155, 023 36, 637 0 15, 041 0 0	15, 392 2, 912 0 2, 496 0 0	31.00 40.00 41.00 42.00
50. 00 05000 OPERATING ROOM	0	105, 104	34, 453	78, 044	7, 696	50.00
51.00 05100 RECOVERY ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 57.00 05700 CT SCAN	0	0 84, 944 18, 608	0 20, 686	0 41, 198 23, 035	0 3, 302 182	51.00 54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY	0 0 0	9, 027 20, 842 86, 451	1, 784 5, 040 14, 449	0 6, 220 0	0 1, 040 2, 912	59.00 60.00
60. 01 06001 0NC0L0GY 60. 02 06002 RADI ATI 0N ONC0L0GY	0	0	0	2, 493	0	60. 01 60. 02
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0 0 37, 309 26, 856	0 6, 702	0 4, 421 16, 237	0 2, 184 0	64.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 0	32, 431 5, 187 0	7, 954 1, 296 0	5, 774 0 0	1, 404 1, 560 0	69. 01
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0 0	0	0 0	0	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	11, 148 150, 473		1, 395 249, 061		90.00 91.00 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	0	45, 670	4, 150	20, 655	364	95.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	223, 977	1, 071, 615	201, 489	655, 334	57, 252	113. 00 118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1, 329	0	104	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.01 19201 PACT REV PHYSI CLANS	0	0	0	0		192.00
192. 02 19202 VISITOR MEALS	2, 469	0	0	0		192. 01 192. 02
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	0	0	0	0	0	192.03
192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES	0	0		0		192. 04 192. 05
192. 06 19206 UROLOGY	0	22, 797	0	0	0	192.06
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19211 PARI SH NURSI NG	0	0 2, 150	0	0		192. 07 192. 08
192. 09 19212 BI OTERRORI SM GRANT	0	2, 130	0	0		192.00
192.1019214 BREAST PUMPS 192.1119208 MGH EMERGENCY PHYSICLANS	0	0	0	0		192. 10 192. 11
192. 12 19209 LUNG CENTER	0	10, 765	0	0		192.11
192. 13 19213 MGH EXPRESS	0	0	0	867		192.13
192. 14 19210 MGH PHYS PRACT MGMT 192. 15 19215 MGH MARI ON SURGEONS	0	63, 503 28, 163		0		192. 14 192. 15
192.16 19216 MGH MGH MED ONC	0	0	0	0	0	192. 16
192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC	0	0	0	272 12		192. 17 192. 18
192.19 19219 MGH FMC MARION	0	27, 065	0	22	0	192. 19
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193.00

Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2020	Worksheet B-1	
				o 06/30/2021	Date/Time Pre	
Cost Center Description	CAFETERIA	CAFETERIA	OPERATION OF	LAUNDRY &	11/29/2021 7: HOUSEKEEPI NG	49 am
Cost Center Description	(MEALS SERVED)	(HOURS	PLANT	LINEN SERVICE	(HOURS OF	
		WORKED)	(SQUARE	(POUNDS OF	SERVICE)	
			FEET)	LAUNDRY)		
	6.01	6.02	7.00	8.00	9.00	100.01
193.01 19301 MGH FMC NORTHWOOD	0	0	-	-		193. 01 193. 02
193.02 19302 MGH FMC GAS CLTY 193.03 19303 MGH HOSPITALISTS	0	0) 395) 0		193.02
193. 04 19304 MGH MAR FAM PRACT	0	0		562		193.03
193. 05 19305 MGH FMC SWAYZEE	0	0				193.05
193. 06 19306 MGH PEDIATRIC CTR	0	13, 232	0) 11		193.06
193.07 19307 MGH SPECIALTY PHYS	0	6, 076	(C	0 0	0	193. 07
193.08 19308 MGH FMC CONVERSE	0	0	C			193. 08
193.09 19309 MGH UPLAND HEALTH	0	0	C			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 0B/GYN 193.15 19315 MGH_RIVER_VIEW_BLDG	0	0				193. 12 193. 15
193. 16 19316 MGH NEONATOLOGY	0	0				193.15
193. 18 19318 MGH WOUND CARE	0	0		-		193.18
194. 00 07963 HEART FAILURE CLINIC	0	0	0	-		194.00
194.01 07950 MOW	0	0	0	0 0	0	194.01
194.0207951 MENTAL HEALTH	0	0	C	0 0	0	194. 02
194. 03 07952 ADVERTI SI NG	0	0	0	-		194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	72		194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0	0			194.05
194. 06 07955 OPI OLD IMPL GRANT	0	3, 930				194.06
194.07 07956 ASTHMA_GRANT 194.08 07957 MGH_SMMPBLDG	0	87		-		194. 07 194. 08
194. 09 07958 MGH AMBUCARE BLDG	0	0		-		194.08
194. 10 07959 MGH 106 LYONS BLDG	0	0				194.10
194. 11 07960 FAI RMOUNT	0	0	0			194. 11
194. 12 07961 GAS CI TY	0	0	C	0 0	0	194. 12
194. 13 07969 LYONS	0	0	C	-		194. 13
194. 14 07964 WABASH	0	0	C			194.14
194. 15 07965 TOBACCO GRANT	0	1, 947	0	-		194.15
194. 16 07966 HRSA NETWORK DEV PLANNI NG	0	0		-		194. 16 194. 17
194. 17 07967 HRSA_OPIOLD_PLANNING 194. 18 07962 ECHO_GRANT	0	154				194.17
194. 19 07968 RURAL QI GRANT	0	2, 598				194.10
194. 20 07970 MGH DI ABETES GRANT	0	2,0,0				194.20
194.21 07971 MGH MGH ORTHO	0	0	C	0 0		194. 21
194.2207972 MGH BELLA BLDG	0	0	(C	0 0	0	194. 22
194. 23 07973 DI ABETES GRANT	0	0	C	0 0		194. 23
194. 24 07974 MGH NORTHWOOD BLDG	0	0	0	0		194.24
194. 25 07975 MGH MGH ORTHO	0	0	C	0 0		194.25
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	2, 187, 249	2, 163, 401	10, 312, 512	573, 900		201.00
Part I)	2,107,249	2, 103, 401	10, 512, 512		3,034,111	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	9. 659031	1. 725087	50. 846138	0. 872171	62.910802	203.00
204.00 Cost to be allocated (per Wkst. B,	175, 580	173, 666				•
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 775372	0. 138481	12.887801	0. 141064	3. 526290	205.00
206.00 II) NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENER	AL HOSPITAL Provider CC		Period:	u of Form CMS-2552-10 Worksheet B-1
				From 07/01/2020 To 06/30/2021	Date/Time Prepared:
Cost Center Description	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	11/29/2021 7:49 am
· · · · · · · · · · · · · · · · · · ·	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS 1.00 O0100 NEW CAP REL COSTS BLDG & FIXT 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL 6.00 6.00 O0600 MAINTENANCE & REPAIRS 6.01 O0601 CAFETERIA 6.02 O0602 CAFETERIA 7.00 O0700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 O0900 HOUSEKEEPING 10.00 01000 DI ETARY 3.00 O1300 NURSING ADMINISTRATION STRATION STRATION	86, 123	3			1.00 4.00 5.00 6.00 6.01 6.02 7.00 8.00 9.00 10.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 101500 PHARMACY		0 0	10	0 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 I NTENSI VE CARE UNI T	48, 605 8, 820			1 0 3 0	30.00 31.00
40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0 8, 280 0 0	34, 778 0 0		0 0 1 0 0 0 0 0	40.00 41.00 42.00 43.00
ANCI LLARY SERVICE COST CENTERS 50.00 IOSOOOI OPERATI NG ROOM			1	3 0	50.00
51. 00 05100 RECOVERY ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC 57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)				0 0 2 0 0 0 0 0	51. 00 51. 00 54. 00 57. 00 58. 00
59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 60.01 06001 ONCOLOGY 60.02 06002 RADI ATI ON		20, 842 0 0 0 0 0 0		4 0 6 0 0 0 0 0	59.00 60.00 60.01 60.02
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY		0 0 37, 309 26, 856 32, 431		0 0 2 0 0 0 3 0	64.00 65.00 66.00 69.00
69. 01 06901 CARDI AC REHAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS		5, 187 0 0 0 0		0 0 0 0 0 0 0 0 100	69. 01 71. 00 72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC				0 0	
90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 0BSERVATION BEDS (DISTINCT PART)	1, 262			0 0 0	90.00 91.00 92.00 92.01
0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	C	45, 670		1 0	95.00
SPECIAL PURPOSE COST CENTERS113.00INTEREST EXPENSE118.00SUBTOTALS (SUM OF LINES 1 through 117)	66, 967	697, 982		1 100	113. 00 118. 00
NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	00, 707	1		0 0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 192.01 19201 PACT REV PHYSI CLANS 192.02 19202 VISI TOR MEALS 192.03 19203 GREAT BEGI NNI NGS/MATERNAL 192.04 19204 LI FELI NE		0 0 0 0 0 2,544 0 0			192. 00 192. 01 192. 02 192. 03 192. 03
192. 05 19205 OWNED PROPERTIES 192. 06 19206 UROLOGY 192. 07 19207 PHYSICIANS' PRIVATE OFFICES 192. 08 19211 PARISH NURSING				0 0 4 0 0 0 0 0	192. 05 192. 06 192. 07 192. 07 192. 08
192. 09 19212 BLOTERRORI SM GRANT 192. 10 19214 BREAST PUMPS 192. 11 19208 MGH EMERGENCY PHYSICIANS 192. 12 19209 LUNG CENTER 192. 13 19213 MGH EXPRESS) 0 0 0 0 0 0 0 0 0 0 30, 481		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. 09 192. 10 192. 11 192. 11 192. 12 192. 13
192. 14 192. 15 192. 15 192. 15 192. 16 192. 16 192. 17 192. 17 192. 17 192. 18 192. 18 192. 18 192. 18 192. 18				0 0 6 0 0 0 4 0 0	192. 14 192. 15 192. 16 192. 16 192. 17 192. 18
192. 19 19218 MGH FALRM MED ASSOC 192. 19 19219 MGH FMC MARION				0 0 3 0	192. 18

	cial Systems TON - STATISTICAL BASIS	MARION GENER	Provi der CC	CN: 15-0011	Peri od:	u of Form CMS-2552- Worksheet B-1
COST ALLOCAT				5N. 15 0011	From 07/01/2020 To 06/30/2021	Date/Time Prepared 11/29/2021 7:49 an
	Cost Center Description	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	1172772021 7.47 all
I		10.00	13.00	14.00	15.00	
193. 01 193.01 193. 02 19302 193. 03 19303 193. 04 19304 193. 05 19305 193. 06 19306 193. 07 19307 193. 08 19308 193. 09 19307 193. 09 19307 193. 01 19310 193. 10 19311 193. 12 19312 193. 14 19311 193. 15 19313 193. 16 19316 193. 16 19313 194. 00 07953 194. 00 07951 194. 00 07953 194. 00 07954 194. 00 07955 194. 01 07959 194. 10 07960 194. 10 07961 194. 12 07961 194. 13 07969 194. 14 07966 194. 13 07966 194. 14 07966 194. 12	MGH RIVER VIEW BLDG MGH NEONATOLOGY MGH WOUND CARE HEART FAILURE CLINIC MOW MENTAL HEALTH ADVERTISING MGH WORK SOLUTIONS MGH TAYLOR UNIVERSITY OPIOID IMPL GRANT ASTHMA GRANT MGH SMMP BLDG MGH AMBUCARE BLDG MGH AMBUCARE BLDG MGH 106 LYONS BLDG FAIRMOUNT GAS CITY LYONS WABASH TOBACCO GRANT HRSA NETWORK DEV PLANNING HRSA OPIOID PLANNING			1	$ \begin{array}{c} 0 \\ 1 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\$	193. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. 194. <t< td=""></t<>
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers					200. 201.
202.00 203.00	Cost to be allocated (per Wkst. B, Part I)	1, 426, 200 16. 560036		951, 05		202.
203.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	287, 136		9, 510. 52000 115, 50		
205.00	Unit cost multiplier (Wkst. B, Part II)	3. 334022	0. 102301	1, 155. 00000	2, 596. 920000	205.
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.

Health Fina	ncial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/29/2021 7:	pared: 49 am
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS	1					
	0 ADULTS & PEDI ATRI CS	16, 425, 917		16, 425, 91		16, 425, 917	
	O INTENSIVE CARE UNIT	4, 934, 602		4, 934, 60	02 0	4, 934, 602	
	0 SUBPROVI DER – I PF	0			0 0	0	
	0 SUBPROVI DER – I RF	3, 799, 890		3, 799, 89	0 0	3, 799, 890	41.00
42.00 0420	0 SUBPROVI DER	0			0 0	0	42.00
43.00 0430	0 NURSERY	2, 296, 048		2, 296, 04	18 0	2, 296, 048	43.00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	15, 296, 814		15, 296, 81	4 0	15, 296, 814	50.00
	O RECOVERY ROOM	0			0 0	0	51.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	8, 714, 672		8, 714, 67	72 0	8, 714, 672	54.00
	O CT SCAN	1, 534, 696		1, 534, 69	96 0	1, 534, 696	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	835, 196		835, 19	96 0	835, 196	58.00
	O CARDI AC CATHETERI ZATI ON	3, 483, 022		3, 483, 02	22 0	3, 483, 022	59.00
60.00 0600	0 LABORATORY	12, 314, 794		12, 314, 79	94 0	12, 314, 794	60.00
60.01 0600	1 ONCOLOGY	2, 392, 546		2, 392, 54		2, 392, 546	60.01
60.02 0600	2 RADIATION ONCOLOGY	0			0 0	0	60.02
64.00 0640	O INTRAVENOUS THERAPY	0			0 0	0	64.00
65.00 0650	0 RESPI RATORY THERAPY	4,054,143	0	4, 054, 14	13 0	4, 054, 143	65.00
66.00 0660	O PHYSI CAL THERAPY	3, 980, 620	0	3, 980, 62	20 0	3, 980, 620	66.00
	0 ELECTROCARDI OLOGY	2, 419, 331		2, 419, 33		2, 419, 331	
	1 CARDI AC REHAB	537,093		537, 09		537, 093	•
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0		00770	0 0	0	
	O IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	O DRUGS CHARGED TO PATIENTS	20, 635, 248		20, 635, 24	-	20, 635, 248	
	ATIENT SERVICE COST CENTERS	20/000/210		20/000/2		20/000/210	10100
	O CLINIC	1, 963, 458		1, 963, 45	58 0	1, 963, 458	90.00
	O EMERGENCY	11, 792, 487		11, 792, 48		11, 792, 487	•
	0 OBSERVATION BEDS (NON-DISTINCT PART)	3, 964, 740		3, 964, 74		3, 964, 740	•
	1 OBSERVATION BEDS (DISTINCT PART)	0		3, 704, 7-	0 0	3, 704, 740	•
	R REIMBURSABLE COST CENTERS	0			0 0	0	72.01
	O AMBULANCE SERVICES	2, 382, 467		2, 382, 46	57 0	2, 382, 467	95.00
	I AL PURPOSE COST CENTERS	2, 302, 407		2, 302, 40	0	2, 302, 407	95.00
	OINTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	123, 757, 784	0	123, 757, 78	34 0	123, 757, 784	
200.00	Less Observation Beds	3, 964, 740		3, 964, 74		3, 964, 740	
201.00	Total (see instructions)	3, 964, 740					
202.00	Total (See Thisti uctions)	119, 793, 044	0	119, 793, 02	••• U	119, 793, 044	1202.00

Health Financial Systems		MARION GENERA	L HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF CO	STS TO CHARGES		Provider CO	CN: 15-0011	Peri od:	Worksheet C	
					From 07/01/2020	Part I	
					To 06/30/2021		pared:
				XVIII	llooni tol	11/29/2021 7: PPS	49 am
				XVIII	Hospi tal	PPS	
Cost Costor Do		Lung di and	Charges	Tatal (aal		TEEDA	
Cost Center De	scription	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SE	DVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30.00 03000 ADULTS & PEDIA		14, 581, 569		14, 581, 5	(0	1	30.00
31.00 03100 I NTENSI VE CARE		6, 838, 458		6, 838, 4	58		31.00
40.00 04000 SUBPROVI DER -		0			0		40.00
41.00 04100 SUBPROVI DER -	I RF	3, 686, 820		3, 686, 8	20		41.00
42.00 04200 SUBPROVI DER		0			0		42.00
43.00 04300 NURSERY		2, 483, 826		2, 483, 8	26		43.00
ANCILLARY SERVICE CO		r		1		1	
50.00 05000 OPERATING ROOM		27, 887, 993	82, 157, 879	110, 045, 8			
51.00 05100 RECOVERY ROOM		0	0		0 0.000000		
54.00 05400 RADI OLOGY-DI AG	NOSTIC	1, 802, 802	28, 490, 266				
57.00 05700 CT SCAN		6, 051, 161	36, 588, 251	42, 639, 4			
58.00 05800 MAGNETIC RESON	ANCE IMAGING (MRI)	326, 559	3, 546, 966	3, 873, 5	25 0. 215617	0. 000000	58.00
59.00 05900 CARDI AC CATHET	ERI ZATI ON	3, 764, 960	6, 880, 438	10, 645, 3	98 0. 327186	0.00000	59.00
60. 00 06000 LABORATORY		4, 249, 773	17, 054, 748	21, 304, 5	0. 578037	0.000000	60.00
60. 01 06001 ONCOLOGY		27, 416	6, 279, 978	6, 307, 3	0. 379324	0.00000	60.01
60.02 06002 RADIATION ONCO	LOGY	0	0		0 0.000000	0.00000	60.02
64.00 06400 INTRAVENOUS TH	ERAPY	0	0		0 0.000000	0.00000	64.00
65.00 06500 RESPI RATORY TH	ERAPY	2, 014, 650	5, 894, 847	7, 909, 4	97 0. 512566	0. 000000	65.00
66.00 06600 PHYSI CAL THERA	PY	5, 209, 409	5, 871, 552	11, 080, 9	61 0. 359231	0. 000000	66.00
69.00 06900 ELECTROCARDI OL	OGY	4, 199, 397	10, 473, 237	14, 672, 6	0. 164887	0. 000000	69.00
69. 01 06901 CARDI AC REHAB		1,000	902, 448	903, 4	48 0. 594492	0.000000	69.01
71.00 07100 MEDICAL SUPPLI	ES CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	71.00
72.00 07200 IMPL. DEV. CHA	RGED TO PATIENTS	o	0		0 0.000000	0.000000	72.00
73.00 07300 DRUGS CHARGED	TO PATIENTS	13, 152, 010	89, 277, 435	102, 429, 4	45 0. 201458	0.00000	73.00
OUTPATIENT SERVICE C							
90.00 09000 CLINIC		4,000	2, 565, 558	2, 569, 5	58 0. 764123	0.00000	90.00
91.00 09100 EMERGENCY		12, 106, 542	66, 517, 288				
	DS (NON-DISTINCT PART)	0	9, 259, 690				
92. 01 09201 OBSERVATI ON BE		o	0		0 0. 000000		
OTHER REIMBURSABLE C		<u> </u>	0		0 0.000000	0.00000	/2.01
95. 00 09500 AMBULANCE SERV		0	4, 278, 815	4, 278, 8	15 0. 556805	0,00000	95.00
SPECIAL PURPOSE COST		UU	4,270,015	4,210,0	0. 00000	0.00000	33.00
113. 00 11300 I NTEREST EXPEN				1		1	113.00
200.00 Subtotal (see		108, 388, 345	376, 039, 396	484, 427, 7	11		200.00
201.00 Less Observati		100, 300, 345	570, 037, 390	404, 427, 7	+ I		200.00
201.00 [Less observati 202.00 [Total (see ins		108, 388, 345	376, 039, 396	484, 427, 7	41		201.00
		100, 300, 340	570,037,390	404,427,7	+ 1	I	1202.00

	Financial Systems	MARION GENERAL			u of Form CMS-	-2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pro 11/29/2021 7:	epared: :49 am
			Title XVIII	Hospi tal	PPS	_
	Cost Center Description	PPS Inpatient Ratio				
		11.00				
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					1 20 00
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
40.00	04000 SUBPROVIDER - IPF					40.00
41.00	04100 SUBPROVIDER - IRF					41.00
42.00	04200 SUBPROVI DER					42.00
43.00	04300 NURSERY					43.00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 139004				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 287679				54.00
57.00	05700 CT SCAN	0. 035992				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 215617				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 327186				59.00
60.00	06000 LABORATORY	0. 578037				60.00
60.01	06001 ONCOLOGY	0. 379324				60.01
60.02	06002 RADI ATI ON ONCOLOGY	0. 000000				60.02
64.00	06400 INTRAVENOUS THERAPY	0. 000000				64.00
65.00	06500 RESPI RATORY THERAPY	0. 512566				65.00
66.00	06600 PHYSI CAL THERAPY	0. 359231				66.00
69.00	06900 ELECTROCARDI OLOGY	0. 164887				69.00
69.01	06901 CARDI AC REHAB	0. 594492				69.01
	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	07300 DRUGS CHARGED TO PATIENTS	0. 201458				73.00
75.00	OUTPATIENT SERVICE COST CENTERS	0.201430				/ 3.00
90.00	09000 CLINIC	0. 764123				90.00
	09100 EMERGENCY	0. 149986				91.00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 428172				91.00
92.00 92.01	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0. 428172				92.00
72. UI	OTHER REIMBURSABLE COST CENTERS	0.000000				92.01
05 00		0 554005				05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0. 556805				95.00
112 00		1				112 00
	11300 INTEREST EXPENSE					113.00
200.00						200.00
201.00						201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/29/2021 7:	pared: 49 am
	-	Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDI ATRI CS	16, 425, 917		16, 425, 91		16, 425, 917	
31.00 03100 INTENSIVE CARE UNIT	4, 934, 602		4, 934, 60	02 0	4, 934, 602	
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	40.00
41. 00 04100 SUBPROVIDER – IRF	3, 799, 890		3, 799, 89	0 0	3, 799, 890	
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
43. 00 04300 NURSERY	2, 296, 048		2, 296, 04	8 0	2, 296, 048	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	15, 296, 814		15, 296, 81	4 0	15, 296, 814	50.00
51.00 05100 RECOVERY ROOM	0			0 0	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	8, 714, 672		8, 714, 67	/2 0	8, 714, 672	54.00
57.00 05700 CT SCAN	1, 534, 696		1, 534, 69	06 0	1, 534, 696	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	835, 196		835, 19	06 0	835, 196	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 483, 022		3, 483, 02	22 0	3, 483, 022	59.00
60. 00 06000 LABORATORY	12, 314, 794		12, 314, 79	04 0	12, 314, 794	60.00
60. 01 06001 ONCOLOGY	2, 392, 546		2, 392, 54	6 0	2, 392, 546	60. 01
60. 02 06002 RADIATION ONCOLOGY	0			0 0	0	60.02
64.00 06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	4, 054, 143	0	4, 054, 14	3 0	4, 054, 143	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 980, 620	0	3, 980, 62	20 0	3, 980, 620	66.00
69.00 06900 ELECTROCARDI OLOGY	2, 419, 331		2, 419, 33	0 0	2, 419, 331	69.00
69. 01 06901 CARDI AC REHAB	537,093		537, 09	03 0	537, 093	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 635, 248		20, 635, 24	8 0	20, 635, 248	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 963, 458		1, 963, 45	58 0	1, 963, 458	90.00
91. 00 09100 EMERGENCY	11, 792, 487		11, 792, 48		11, 792, 487	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 964, 740		3, 964, 74		3, 964, 740	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0, 70 1, 710	
OTHER REIMBURSABLE COST CENTERS				0		12101
95. 00 09500 AMBULANCE SERVICES	2, 382, 467		2, 382, 46	07 0	2, 382, 467	95.00
SPECIAL PURPOSE COST CENTERS	2,002,407		2,002,40		2,002,407	/0.00
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	123, 757, 784	0	123, 757, 78	34 0	123, 757, 784	
201.00 Less Observation Beds	3, 964, 740		3, 964, 74		3, 964, 740	
202.00 Total (see instructions)	119, 793, 044					
	1 117, 775, 044	0	1 117, 775, 02		117, 775, 044	1202.00

Health Fi	nancial Systems	MARION GENERA	L HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0011	Period: Worksheet C		
					From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre 11/29/2021 7:	pared:
			Ti +1	e XIX	Hospi tal	Cost	49 dili
			Charges	e Al A		0031	
	Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
	cost center bescription	inpatrent	outputrent	+ col. 7)	Ratio	Inpati ent	
				, cor. //	No cr o	Ratio	
		6.00	7.00	8.00	9.00	10.00	
I N	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	14, 581, 569		14, 581, 56	59		30.00
	100 I NTENSI VE CARE UNI T	6, 838, 458		6, 838, 45	58		31.00
	000 SUBPROVIDER - IPF	0			0		40.00
	100 SUBPROVIDER - IRF	3, 686, 820		3, 686, 82	20		41.00
	200 SUBPROVI DER	0		-//	0		42.00
	300 NURSERY	2, 483, 826		2, 483, 82	26		43.00
	CILLARY SERVICE COST CENTERS			_//.			
	000 OPERATI NG ROOM	27, 887, 993	82, 157, 879	110, 045, 87	0. 139004	0.00000	50.00
51.00 05	100 RECOVERY ROOM	0	0		0 0.000000	0. 000000	51.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	1, 802, 802	28, 490, 266	30, 293, 06	0. 287679	0. 000000	54.00
	700 CT SCAN	6,051,161	36, 588, 251	42, 639, 41		0. 000000	
58.00 05	800 MAGNETIC RESONANCE IMAGING (MRI)	326, 559	3, 546, 966	3, 873, 52	0. 215617	0. 000000	58.00
	900 CARDI AC CATHETERI ZATI ON	3, 764, 960	6, 880, 438			0. 000000	59.00
60.00 06	000 LABORATORY	4, 249, 773	17,054,748	21, 304, 52	0. 578037	0. 000000	60.00
	001 ONCOLOGY	27, 416	6, 279, 978			0. 000000	
	002 RADIATION ONCOLOGY	0	0		0 0.000000	0. 000000	60.02
	400 INTRAVENOUS THERAPY	0	0		0 0.000000	0. 000000	64.00
65.00 06	500 RESPI RATORY THERAPY	2,014,650	5, 894, 847	7, 909, 49	0. 512566	0. 000000	65.00
66.00 06	600 PHYSI CAL THERAPY	5, 209, 409	5, 871, 552	11, 080, 96	0. 359231	0. 000000	66.00
69.00 06	900 ELECTROCARDI OLOGY	4, 199, 397	10, 473, 237	14, 672, 63	0. 164887	0. 000000	69.00
69.01 06	901 CARDI AC REHAB	1,000	902, 448	903, 44	0. 594492	0. 000000	69.01
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	13, 152, 010	89, 277, 435	102, 429, 44	0. 201458	0. 000000	73.00
OU	TPATIENT SERVICE COST CENTERS						1
90.00 09	000 CLINIC	4,000	2, 565, 558	2, 569, 55	0. 764123	0.00000	90.00
91.00 09	100 EMERGENCY	12, 106, 542	66, 517, 288	78, 623, 83	0. 149986	0. 000000	91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	9, 259, 690				92.00
92.01 09	201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0.000000	0. 000000	92.01
	HER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	500 AMBULANCE SERVI CES	0	4, 278, 815	4, 278, 81	0. 556805	0.00000	95.00
SPI	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	108, 388, 345	376, 039, 396	484, 427, 74	11		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	108, 388, 345	376, 039, 396	484, 427, 74	11		202.00
		· · ·					

31.00 03100 INTENSIVE CARE UNIT 31. 40.00 04000 SUBPROVI DER - 1 PF 40. 41.00 04100 SUBPROVI DER - 1 RF 41. 42.00 04200 SUBPROVI DER - 1 RF 42. 43.00 04300 NURSERY 43. ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.00 05000 PERATIN ROOM 0.000000 51. 51.00 05100 RECOVERY ROOM 0.000000 54. 52.00 05000 CARDIA CATHER ZATION 0.000000 54. 53.00 05000 CARDIA CATHER ZATION 0.000000 59. 60.00 06000 LABORATORY 0.000000 59. 60.00 06000 LABORATORY 0.000000 60. 60.00 06000 RESPIR TATION ONCOLOGY 0.000000 60. 61.00 06000 RESPIR TATION ONCOLOGY 0.000000 60. 62.00 06000 RESPIR TAROW THERAPY 0.000000 60. 63.00 06500 RESPIR TAROW THERAPY 0.000000 60. 64.00 06400 INTRAVENDY THERAPY 0.0000000 61.<	Heal th	Financial Systems	MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	552-10
Cost Center Description PPS Inpatient Ratio 1 30 00 03000 ADULTS & PEDIATRICS 30. 31.00 03100 INTENSIVE CARE UNIT 31. 40.00 04000 SUBPROVIDER - IPF 40. 41.00 40. 41. 42.00 04200 SUBPROVIDER - IPF 42. 43.00 04000 SUBPROVIDER - IPF 42. 43.00 04000 SUBPROVIDER - IPF 43. 44.1.00 04000 SUBPROVIDER - IPF 43. 44.2.00 04200 SUBPROVIDER - IPF 43. 45.00 04300 RECOVERY ROOM 0.000000 551. 50.00 05000 RECOVERY ROOM 0.000000 54. 51.00 05100 RECOVERY ROOM 0.000000 54. 56.00 05600 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 54. 57.00 05700 CARDIAC CATHETERIZATION 0.000000 54. 58.00 05600 MAGNATORY HADAY 0.000000 66. 60.01 06000 INSTANCE IMAGING (MRI) 0.000000 66. 61.00 06000 IRESTIRATION ONCOLOGY	COMPUT	ATION OF RATIO OF COSTS TO CHARGES			From 07/01/2020 To 06/30/2021	Part I Date/Time Prep 11/29/2021 7:4	ared: 9 am
Ratio 11.00 10.00 03000 ADULTS & PEDIATRICS 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31. 40.00 04000 SUBPROVIDER - IPF 40. 41.00 410. 41. 42.00 04200 SUBPROVIDER - IPF 41. 43.00 04300 NURSERV 43. 43.00 04300 NURSERV 43. 44.1 0.00 05000 OPERATINE ROM 0.000000 51.00 05000 REDOUDER 18. 51.00 05000 OPERATINE ROM 0.000000 54. 52.00 05000 CARDIAC CATHETER IZATION 0.000000 59. 59.00 05900 CARDIAC CATHETER IZATION 0.000000 59. 60.00 06000 CARDIAC CATHETER IZATION 0.000000 59. 60.00 06000 INTRAVENUS THERAPY 0.000000 60. 60.00 06000 INTRAVENUS THERAPY 0.000000 64. 60.00 06000 PHYSICAL THERAPY 0.000000 64. 60.00<				Title XIX	Hospi tal	Cost	
11.00 14 INPAT ENT ROUTINE SERVICE COST CENTERS 30.00 030001 ADULTS & PEDIATRI CS 31.00 031001 INTENSI VE CARE UNIT 40.00 040000 SUBPROVI DER - I PF 41.00 041000 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 42.00 04200 SUBPROVI DER 42.00 04200 SUBPROVI DER 42.00 04200 SUBPROVI DER 43.00 03000 RCOVERY ROM 0.000000 51. 51.00 05100 RECOVERY ROM 0.000000 54.00 05400 RADI LOGY-DI AGNOSTI C 0.000000 55.00 05600 CARDIAC CATHETER IXATI ON 0.000000 56.00 05000 CARDIAC CATHETERI ZATI ON 0.000000 56.00 06000 LABDRATORY 0.000000 56.00 06000 RESPI RATIORY 0.000000 56.00 06000 RESPI RATIORY 0.000000 56.00 06000 RESPI RATIORY 0.000000 66.00 06000 RESPI RATIORY 0.000000 66.00 06000 RESPI RATIORY THERAPY 0.0000000 66.00		Cost Center Description					
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40.00 VetOO SUBPROVIDER - IPF 40. 41.00 04100 SUBPROVIDER - IRF 41. 42.00 04200 SUBPROVIDER - IRF 42. 43.00 04200 SUBPROVIDER - IRF 42. 43.00 04200 SUBPROVIDER - IRF 42. 43.00 04200 SUBPROVIDER - IRF 43. 50.00 05000 PERATING ROOM 0.000000 51.00 05100 COND RECOVERY ROOM 0.000000 54.00 05400 RADIOLOCY-DIAGNOSTIC 0.000000 55.00 05500 CARDIAC CATHETRIZATION 0.000000 55. 56.00 05600 LAGONTORY 0.000000 60. 60.01 06001 NOCLOGY 0.000000 60. 60.01 06001 NEANDAY 0.000000 60. 61.00 06600 RESPIRATORY THERAPY 0.000000 60. 62.00 06000 RESPIRATORY THERAPY 0.000000 64. 63.00 06600 RESPIRATORY THERAPY 0.000000 64. 64.00 06400 <td< td=""><td>30.00</td><td>03000 ADULTS & PEDIATRICS</td><td></td><td></td><td></td><td></td><td>30.00</td></td<>	30.00	03000 ADULTS & PEDIATRICS					30.00
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42.00 04200 SUBPROVI DER 42. 43.00 04300 NURSERY 43. ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50. 51.00 05100 RCOVERY ROOM 0.000000 51. 54. 54. 57.00 05700 CT SCAN 0.000000 54. 57. 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58. 59.00 05900 CARDI AC CATHETERI ZATION 0.000000 59. 60.01 60.00 LABORATORY 0.000000 60. 60.00 60.00 60.00 LABORATORY 0.000000 60. 60. 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60. 60. 60. 60.00	40.00	04000 SUBPROVIDER - IPF					40.00
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ANCILLARY SERVICE COST CENTERS							43.00
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58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58. 59.00 05900 CARDIAC CATHETERIZATION 0.000000 60. 60.00 L6BORATORY 0.000000 60. 60.01 06001 NOCLOGY 0.000000 60. 60.01 06001 NOCLOGY 0.000000 60. 60.01 06002 RABRATORY 0.000000 60. 60.01 06001 NUCLOGY 0.000000 60. 61.00 06000 HABRATORY 0.000000 60. 62.00 06500 RESPI RATORY THERAPY 0.000000 64. 65.00 06600 PHYSI CAL THERAPY 0.000000 65. 66.00 06600 PHYSI CAL THERAPY 0.000000 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72. 72.00 07200 IMPL COST CENTERS 90.							57.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 60.00 DABORATORY 0.000000 60. 60.01 06001 LABORATORY 0.000000 60. 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 60. 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 60. 60.01 06000 INTRAVENOUS THERAPY 0.000000 60. 61.00 06600 PHYSI CAL THERAPY 0.000000 65. 62.00 06600 PHYSI CAL THERAPY 0.000000 66. 63.00 06901 CARDI AC REHAB 0.000000 69. 69.01 06901 CARDI AC REHAB 0.000000 69. 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 73.00 DTUGS CHARGED TO PATI ENTS 0.000000 90. 91.00 OP100 EMERGENCY 0.000000							58.00
60.00 06000 LABORATORY 0.000000 60. 60.01 06001 NOCOLOGY 0.000000 60. 60.02 RADI ATI ON ONCOLOGY 0.000000 60. 60.02 RADI ATI ON ONCOLOGY 0.000000 60. 61.00 06400 INTRAVENOUS THERAPY 0.000000 64. 65.00 06500 RESPI RATORY THERAPY 0.000000 65. 66.00 06000 PHYSI CAL THERAPY 0.000000 65. 67.00 06900 ELECTROCARDI OLOGY 0.000000 66. 69.01 06900 ELECTROCARDI OLOGY 0.000000 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72. 72.00 07200 IMPL ES CHARGED TO PATI ENTS 0.000000 72. 72.00 09100 EMEGENCY 0.000000 91. 92. 92. 09100 EMEGENCY 0.000000							
60.01 06001 0NCOLOGY 0.000000 60. 60.02 06002 RADI ATI ON ONCOLOGY 0.000000 60. 64.00 06400 INTRAVENOUS THERAPY 0.000000 65. 65.00 06500 RESPI RATORY THERAPY 0.000000 65. 66.00 06600 PHYSI CAL THERAPY 0.000000 66. 69.00 06600 ELECTROCARDI OLOGY 0.000000 69. 69.01 06901 CARDI AC REHAB 0.000000 69. 69.01 06901 CARDI AC REHAB 0.000000 69. 71.00 07100 MEDL CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 0.017PATI ENT SERVICE COST CENTERS 0.000000 90. 91. 0.00 09000 CLI NI C 0.000000 91. 92.00 092001 OBESRVATI ON BEDS (INCT PART) 0.000000 91. 92.00 09200 OBESRVATI ON BEDS (INT T PART) 0.000000 92. 92.01 09200 OBESRVATI ON BED							
60.02 06002 RADI ATI ON ONCOLOGY 0.000000 60. 64.00 06400 INTRAVENOUS THERAPY 0.000000 64. 65.00 06500 RESPI RATORY THERAPY 0.000000 65. 66.00 06600 PHYSI CAL THERAPY 0.000000 65. 67.00 06900 ELECTROCARDI OLOGY 0.000000 69. 69.01 06900 ELECTROCARDI OLOGY 0.000000 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 71. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 90.00 09000 CLI NI C 0.000000 90. 91.00 09000 CLI NI C 0.000000 91. 92.00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 92.01 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0.0000000 92. 95.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
64.00 06400 INTRAVENOUS THERAPY 0.000000 64. 65.00 06500 RESPI RATORY THERAPY 0.000000 65. 66.00 06600 PHYSI CAL THERAPY 0.000000 66. 69.00 06900 ELECTROCARDI OLOGY 0.000000 69. 71.00 06901 CARDI AC REHAB 0.000000 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71. 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0.000000 72. 73.00 D7300 DRUGS CHARGED TO PATIENTS 0.000000 72. 90.00 O9000 CLINIC 0.000000 90. 91.00 09000 CLINIC 0.000000 91. 92.01 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 91. 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 92. 95.00 OPSOO AMBULANCE SERVICES 0.000000 92. 95.00 D9500 AMBULANCE SERVICES 0.000000 92. 95.00 OPSOO AMBULANCE SERVICES							
65.00 06500 RESPIRATORY THERAPY 0.000000 65. 66.00 06600 PHYSICAL THERAPY 0.000000 66. 69.00 06900 ELECTROCARDIOLOGY 0.000000 69. 69.01 06901 CARDIAC REHAB 0.000000 69. 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 73.00 07200 DRUGS CHARGED TO PATIENTS 0.000000 73. 0UTPATIENT SERVICE COST CENTERS 0.000000 90. 90. 90.00 09000 CLINIC 0.000000 91. 91.00 09100 EMERGENCY 0.000000 91. 92.01 09201 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 92.01 09201 DESERVATION BEDS (DISTINCT PART) 0.000000 92. 95.00 OP500 AMBULANCE SERVICES 0.000000 92. 95.01 09500 AMBULANCE SERVICES 0.000000 95. 95.01 09500 AMBULANCE							
66.00 06600 PHYSI CAL THERAPY 0.000000 66. 69.00 06900 ELECTROCARDI OLOGY 0.000000 69. 69.01 06900 CARDI AC REHAB 0.000000 69. 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 0017PATI ENT SERVI CE COST CENTERS 0.000000 90. 91.00 09100 EMERGENCY 0.000000 91. 92.01 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 92. 92.01 09200 [BBERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92. 95. 95.00 09500 [AMBULANCE SERVI CES 0.000000 92. 92. 95. 95. 95.00 09500 [AMBULANCE SERVI CES 0.000000 92. 95. 95. 95.00 09500 [AMBULANCE SERVI CES 0.000000 92. 95. 95. 95. 95. 95. 95. 92. 92. 92. 92. 92. <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
69.00 06900 ELECTROCARDIOLOGY 0.000000 69. 69.01 06901 CARDIAC REHAB 0.000000 69. 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 0UTPATIENT SERVICE COST CENTERS 0.000000 73. 90.00 09000 CLINIC 0.000000 90. 91.00 09100 EMERGENCY 0.000000 91. 92.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 92.01 09201 DBSERVATION BEDS (DISTINCT PART) 0.000000 92. 92.01 09200 MBULANCE SERVICES 0.000000 92. 92.01 09500 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
69.01 06901 CARDI AC REHAB 0.000000 69. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 0UTPATI ENT SERVICE COST CENTERS 0.000000 73. 90.00 09000 CLI NI C 0.000000 90. 91.00 09100 EMERGENCY 0.000000 91. 92.01 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92.01 09200 MBULANCE SERVICES 0.000000 92. 91.13.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 200.							66.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 0017PATI ENT SERVICE COST CENTERS 0.000000 90. 91. 90. 00 09100 EMERGENCY 0.000000 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 95. 00 09200 AMBURABEE COST CENTERS 95. 95. 95. 01 09500 AMBURABEE COST CENTERS 95. 95. 02 09500 AMBURABES ERVICES 0.000000 92. 01 00000 Subtotal (see instructions) 13.00 113.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>69.00</td>							69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 000 09000 CLINIC 0.000000 90. 90.00 09100 EMERGENCY 0.000000 91. 92.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92. 95.00 09200 AMBURABLE COST CENTERS 95. 95. 95.00 09500 AMBURABLE COST CENTERS 95. 91.300 INTEREST EXPENSE 0.000000 92. 92.01 09500 AMBURAGE SERVICES 0.000000 92. 92.01 09500 AMBURABLE COST CENTERS 95. 95. 913.00 INTEREST EXPENSE 0.000000 95. 200.00 Subtotal (see instructions) 200. 200. 201.00 Less Observation Beds 201. 201.							69. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 0UTPATIENT SERVICE COST CENTERS 0.000000 90. 90. 90. 90. 00 09000 CLINIC 0.000000 90. 91. 00 09100 EMERGENCY 0.000000 91. 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92. 95. 00 09500 AMBULANCE SERVICES 0.000000 95. 95. 00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 200. 201. 201. 00 Less Observation Beds 201. 201.							71.00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 90. 91. 00 09100 EMERGENCY 0.000000 91. 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 92. 92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0.000000 92. 95. 00 OP5000 AMBULANCE SERVICES 0.000000 95. 95. 00 OP5000 AMBULANCE SERVICES 0.000000 95. 9113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 200. 00 Subtotal (see instructions) 200. 200. 201. 201. 00 Less Observation Beds 201. 201. 201.							72.00
90. 00 09000 CLINIC 0.000000 90. 91. 00 09100 EMERGENCY 0.000000 91. 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 92. 92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0.000000 92. 0THER REI MBURSABLE COST CENTERS 0.000000 95. 95. 00 09500 AMBULANCE SERVICES 0.000000 95. SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113. 200. 00 Subtotal (see instructions) 200. 200. 201. 00 Less Observation Beds 201.	73.00		0. 000000				73.00
91. 00 09100 EMERGENCY 0.000000 91. 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0.000000 92. 07HER REI MBURSABLE COST CENTERS 0.000000 92. 95. 00 09500 AMBULANCE SERVICES 0.000000 95. SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113. 200. 00 Subtotal (see instructions) 200. 200. 200. 201.							
92. 00 92.01 09200 09201 0BSERVATION BEDS (NON-DISTINCT PART) 009201 0.000000 0.000000 92. 92. 92. 92. 92. 92. 92. 92. 92. 92.							90.00
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 92. 01 07HER REI MBURSABLE COST CENTERS 0.000000 95.	91.00	09100 EMERGENCY	0. 000000				91.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113. 200.00 Subtotal (see instructions) 200. 201.00 Less Observation Beds 201.	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
95. 00 09500 AMBULANCE SERVICES 0.000000 95. SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113. 113.00 10000000 113.00 113.00 1000000000000000000000000000000000000	92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
SPECIAL PURPOSE COST CENTERS 113.00 11300 200.00 Subtotal (see instructions) 201.00 Less Observation Beds		OTHER REIMBURSABLE COST CENTERS					
113.00 11300 INTEREST EXPENSE 113. 200.00 Subtotal (see instructions) 200. 201.00 Less Observation Beds 201.	95.00	09500 AMBULANCE SERVICES	0.000000				95.00
200.00 201.00Subtotal (see instructions) Less Observation Beds200. 201.		SPECIAL PURPOSE COST CENTERS					
200.00 201.00Subtotal (see instructions) Less Observation Beds200. 201.	113.00	11300 INTEREST EXPENSE				1	113.00
201. 00 Less Observation Beds 201.							200.00
							201.00
	202.00						202.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part I Date/Time Pre	narod
				10 00/ 30/ 2021	11/29/2021 7:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1		1			
30. 00 ADULTS & PEDIATRICS	2, 221, 043	0	2, 221, 04			
31.00 INTENSIVE CARE UNIT	578, 369		578, 36	9 3, 597		
40. 00 SUBPROVIDER - IPF	0	0		0 0		40.00
41.00 SUBPROVIDER - IRF	489, 571	0	489, 57	1 2, 858		41.00
42. 00 SUBPROVI DER	0	0		0 0		42.00
43.00 NURSERY	60, 562		60, 56			43.00
200.00 Total (lines 30 through 199)	3, 349, 545		3, 349, 54	5 23, 147		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	(6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	4 57((70.077				1 00 00
30.00 ADULTS & PEDIATRICS	4, 576		•			30.00
31. 00 INTENSIVE CARE UNIT	955	153, 554				31.00
40.00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	2, 109	361, 272				41.00
42. 00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	7,640	1, 186, 903	1			200. 00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/29/2021 7:	pared: 49 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 OPERATING ROOM	1, 709, 253	110, 045, 872	0. 01553	7, 993, 681	124, 158	
51.00 05100 RECOVERY ROOM	0		0.00000		0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1,009,354	30, 293, 068	0. 03332	805, 002	26, 823	54.00
57.00 05700 CT SCAN	98, 117	42, 639, 412	0.00230	2, 944, 412	6, 775	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	87, 996	3, 873, 525	0. 02271	7 125, 552	2, 852	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	280, 748	10, 645, 398	0. 02637	993, 464	26, 201	59.00
60. 00 06000 LABORATORY	850, 041	21, 304, 521	0. 03990	1, 688, 405	67, 367	60.00
60. 01 06001 ONCOLOGY	57, 370	6, 307, 394	0.00909	6 11, 345	103	60.01
60. 02 06002 RADIATION ONCOLOGY	0	0	0. 00000	0 0	0	60. 02
64.00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	361, 737	7, 909, 497	0. 04573	656, 162	30, 010	65.00
66.00 06600 PHYSI CAL THERAPY	347, 873	11, 080, 961	0. 03139	891, 888	28, 000	66.00
69.00 06900 ELECTROCARDI OLOGY	369, 618	14, 672, 634	0. 02519	1, 745, 414	43, 969	69.00
69. 01 06901 CARDI AC REHAB	65, 783	903, 448	0. 07281	3 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	593, 635	102, 429, 445			29, 911	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	234, 282	2, 569, 558	0.09117	6 3, 581	327	90.00
91.00 09100 EMERGENCY	798, 471					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	536,096				0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		0.00000		0	92.01
OTHER REI MBURSABLE COST CENTERS	1			-1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	7,400,374	452, 558, 253		27, 542, 535	432, 432	

Health Financial Systems	MARION GENERA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider C		Period: From 07/01/2020 To 06/30/2021		epared: 49 am
		Title	× XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown	0	Post-Stepdowr	n Cost	Medi cal	
	Adjustments		Adj ustments		Education 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 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
40. 00 04000 SUBPROVI DER – I PF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVIDER - IRF	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	
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4.00	5.00	6.00	7.00	8.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	15, 12			
31.00 03100 INTENSIVE CARE UNIT		0	3, 59			
40.00 04000 SUBPROVIDER - IPF	0	0		0 0.00		
41.00 04100 SUBPROVIDER - IRF	0	0	2, 85			
42.00 04200 SUBPROVI DER	0	0		0 0.00		
43.00 04300 NURSERY		0	1, 57			
200.00 Total (lines 30 through 199)		0	23, 14	7	7, 640	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through Cost (col. 7 x					
	cost (col. 7 x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					-
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
40. 00 104000 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF	0					40.00
41.00 04200 SUBPROVIDER - TRF 42.00 04200 SUBPROVIDER	0					41.00
42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY	0					42.00
	0					200.00
200.00 Total (lines 30 through 199)						

Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/29/2021 7:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	I Allied Health	Allied Health	
	Anesthetist	Post-Stepdown	-	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1			
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 ONCOLOGY	0	0		0 0	0	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0	60. 02
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
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 CLI NI C	0	0	I	0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021		norod.
				10 06/30/2021	11/29/2021 7:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 110, 045, 872		
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 30, 293, 068		
57.00 05700 CT SCAN	0	0		0 42, 639, 412		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 3, 873, 525		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 10, 645, 398		
60. 00 06000 LABORATORY	0	0		0 21, 304, 521		60.00
60. 01 06001 0NC0L0GY	0	0		0 6, 307, 394	0.000000	60. 01
60. 02 06002 RADIATION ONCOLOGY	0	0		0 0	0.000000	60. 02
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 7, 909, 497	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 11, 080, 961	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 14, 672, 634	0.00000	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 903, 448	0.00000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 102, 429, 445	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS	·	•	•			
90. 00 09000 CLINIC	0	0	1	0 2, 569, 558	0.000000	90.00
91.00 09100 EMERGENCY	0	0		0 78, 623, 830	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 9, 259, 690	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 452, 558, 253		200.00

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	oarod:
				10 00/ 30/ 2021	11/29/2021 7:4	49 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1			1		
50.00 05000 OPERATI NG ROOM	0.000000	7, 993, 681		0 15, 253, 097	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	805, 002		0 6, 137, 438		54.00
57.00 05700 CT SCAN	0.000000	2, 944, 412		0 7, 818, 399	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	125, 552		0 964, 019	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	993, 464		0 2, 257, 081	0	59.00
60. 00 06000 LABORATORY	0.000000	1, 688, 405		0 1, 655, 506	0	60.00
60. 01 06001 ONCOLOGY	0.000000	11, 345		0 2, 182, 133	0	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000	0		0 0	0	60.02
64.00 06400 I NTRAVENOUS THERAPY	0.000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	656, 162		0 1, 281, 475	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	891, 888		0 55, 669	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 745, 414		0 2, 491, 752	0	69.00
69. 01 06901 CARDI AC REHAB	0.000000	0		0 292, 776	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	5, 160, 551		0 31, 889, 986	0	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
90. 00 09000 CLINIC	0.000000	3, 581		0 754, 811	0	90.00
91.00 09100 EMERGENCY	0.000000	4, 523, 078		9, 844, 768	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 1, 263, 346		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS			ı	·		-
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		27, 542, 535		0 84, 142, 256	0	200.00

Heal th Financ		MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI ONMENT	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
					From 07/01/2020 To 06/30/2021	Part V Date/Time Pre	narod
					10 00/ 30/ 2021	11/29/2021 7:	49 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
(Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00		(see inst.)	(see inst.)	5.00	
		1.00	2.00	3.00	4.00	5.00	
	ARY SERVICE COST CENTERS	0 120004	15 252 007		0 0	2 120 241	50.00
	RECOVERY ROOM	0. 139004 0. 000000			s	2, 120, 241	50.00 51.00
	RADI OLOGY-DI AGNOSTI C	0. 287679			0 0	0 1, 765, 612	
	CT SCAN	0. 287879			0 0	281, 400	•
	MAGNETIC RESONANCE IMAGING (MRI)	0. 215617			0 0	207, 859	•
	CARDIAC CATHETERIZATION	0. 327186			0 0	738, 485	
	LABORATORY	0. 578037	1, 655, 506	34, 14		738, 485 956, 944	60.00
	ONCOLOGY	0. 379324			0 0	827, 735	
	RADIATION ONCOLOGY	0. 379324			0 0	027,733	60.01
	INTRAVENOUS THERAPY	0.000000			0 0	0	64.00
	RESPI RATORY THERAPY	0. 512566			0 0	656, 841	•
	PHYSI CAL THERAPY	0. 359231	55, 669		0 0	19, 998	
	ELECTROCARDI OLOGY	0. 164887	2, 491, 752		0 0	410, 858	•
	CARDI AC REHAB	0. 104887				174, 053	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				033	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0. 000000			0 0	0	72.00
	DRUGS CHARGED TO PATIENTS	0. 201458			0 9, 120	6, 424, 493	•
	TENT SERVICE COST CENTERS	0.201430	51,007,700	I	7,120	0, 424, 473	/ 5. 00
90.00 09000		0. 764123	754, 811		0 0	576, 768	90.00
	EMERGENCY	0. 149986			0 0	1, 476, 577	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 428172			0 0	540, 929	
	OBSERVATION BEDS (DISTINCT PART)	0.000000			0 0	0	92.01
	REIMBURSABLE COST CENTERS				-		
	AMBULANCE SERVICES	0. 556805			0		95.00
200.00	Subtotal (see instructions)		84, 142, 256	34, 14	0 9, 120	17, 178, 793	200.00
	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		84, 142, 256	34, 14	0 9, 120	17, 178, 793	202.00

Heal th	Financial Systems	MARION GENER	In Lie	u of Form CMS-	2552-10		
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/29/2021 7:	
				XVIII	Hospi tal	PPS	
			sts				
	Cost Center Description	Cost Reimbursed	Cost Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coi ns.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
/	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	19, 734	0				60.00
60.01	06001 ONCOLOGY	0	0				60.01
60.02	06002 RADIATION ONCOLOGY	0	0				60. 02
64.00	06400 INTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
69.01	06901 CARDI AC REHAB	0	0				69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 837				73.00
	OUTPATIENT SERVICE COST CENTERS	1	1	1			
	09000 CLI NI C	0		•			90.00
	09100 EMERGENCY	0	-	•			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-				92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0				92.01
	OTHER REIMBURSABLE COST CENTERS		1	1			
	09500 AMBULANCE SERVI CES	0					95.00
200.00	Subtotal (see instructions)	19, 734					200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
202 02	Only Charges	10 704	1 007				202.02
202.00	Net Charges (line 200 - line 201)	19, 734	1, 837				202.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Peri od:	Worksheet D	
		Composite		From 07/01/2020		
		component (CCN: 15-T011	To 06/30/2021	Date/Time Pre 11/29/2021 7:	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	1, 709, 253				893	50.00
51.00 05100 RECOVERY ROOM	0	-	0.00000		0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1,009,354					54.00
57.00 05700 CT SCAN	98, 117				214	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	87, 996	3, 873, 525	0. 02271			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	280, 748					59.00
60. 00 06000 LABORATORY	850, 041	21, 304, 521	0. 03990	0 102, 126	4, 075	60.00
60. 01 06001 ONCOLOGY	57, 370	6, 307, 394	0.00909	6 573	5	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0	0.00000	0 0	0	60.02
64.00 06400 I NTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	361, 737	7, 909, 497	0. 04573	5 49, 950	2, 284	65.00
66. 00 06600 PHYSI CAL THERAPY	347, 873	11, 080, 961	0. 03139	4 2, 339, 546	73, 448	66.00
69. 00 06900 ELECTROCARDI OLOGY	369, 618	14, 672, 634	0. 02519	46, 655	1, 175	69.00
69. 01 06901 CARDI AC REHAB	65, 783	903, 448	0. 07281	3 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	593, 635	102, 429, 445	0.00579	6 320, 360	1, 857	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	234, 282	2, 569, 558	0. 09117	6 244	22	90.00
91.00 09100 EMERGENCY	798, 471	78, 623, 830	0. 01015	6 78, 635	799	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	9, 259, 690	0. 00000	0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0. 00000	0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	6, 864, 278	452, 558, 253		3, 155, 585	86, 804	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-001 Component CCN: 15-1011 Period: From 07/01/2020 To 06/30/2021 Parial: Pate/Time Prepared: 11/29/2021 Parial: Time Prepared: 11/29/2021 Parial: Pate/Time Prepared: Pate/Time Prepared: 11/29/2021 Parial: Pate/Time Prepared: 11/29/2021 Parial: Pate/Time Prepared: 11/29/2021 Parial: Pate/Time Prepared: 11/29/2021 Pate/Time Prepared: Pate/Time Prepared: 11/29/2021 Pate/Time Prepared: Pate/Time Prepared: 12/2021 Pate/Time Pate/	Health Financial Systems	MARION GENERA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Ancount Gool S Component CCN: 15-T011 To 06/30/2021 Date/Time Prepared: 11/29/2021 Intervent Title XVIII Subprovider - IFF PPS ANCILLARY SERVICE COST CENTERS Non Physician Nursing School Nursing School All Lied Heal th Anesthetist All Lied Heal th Post-Stepdown Adjustments All Lied Heal th Post-Stepdown Adjustments All Lied Heal th Post-Stepdown Adjustments 50.00 05000 (PEATI NG ROOM 0 0 0 0 0 0 50.00 50.00 05000 (RADIOLIGY-DI AGNOSTI C 0 0 0 0 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 52.00 59.00 60.00 60.01 58.00 66.00 60.01 66.00 66.00		RVICE OTHER PASS	S Provider C	CN: 15-0011			
Cost Center Description Non Physician Nursing School Nursing School Nursing School All Lied Health Post-Stepdown Cost Adjustments All Lied Health Post-Stepdown Adjustments All Lied Health Post-Stepdown Cost Adjustments ANCILLARY SERVICE COST CENTERS 0 <	THROUGH COSTS		Component	CCN: 15 TO11			narod:
Cost Center Description Non Physician Nursing School Nursing School All Lied Health Anesthetist All Lied Health Post-Stepdown All Lied Health Post-Stepdown All Lied Health Post-Stepdown ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 (DEPRATING ROOM 0 0 0 0 0 0 0 50.00 50.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 54.00 54.00 54.00 54.00 54.00 54.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 <td></td> <td></td> <td>component</td> <td>GCN. 15-1011</td> <td>10 00/30/2021</td> <td></td> <td></td>			component	GCN. 15-1011	10 00/30/2021		
Cost Center Description Non Physician Nursing School Nursing School Nursing School Allied Health Post-Stepdown Allied Health Post-Stepdown Allied Health Post-Stepdown Adjustments Adjustments Adjustments 3.00 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 55.00 55.00 55.00 55.00 55.00 55.00 57.00 57.00 57.00 57.00 59.00 60.00 0 0 0 0 59.00			Title	e XVIII	Subprovider -		
Anesthet is the Cost Post-Stepdown Adjustments Post-Stepdown Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 ANCI LLARY SERVICE COST CENTERS 0 <td></td> <td>r</td> <td></td> <td>1</td> <td></td> <td></td> <td></td>		r		1			
Cost Adjustments Adjustments 1.00 2A 2.00 3A 3.00 50.00 05000 0PERATING ROOM 0	Cost Center Description		Nursing School	Nursing Scho		Allied Health	
I.OO 2A 2.0O 3A 3.0O ANCI LLARY SERVICE COST CENTERS							
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0							
50.00 05000 OPERATING ROM 0		1.00	2A	2.00	3A	3.00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 59.00 05900 (CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.00 LABORATORY 0 0 0 0 0 60.01 06.01 0KOOLOGY 0 0 0 0 0 60.01 60.01 ORCOLOGY 0 0 0 0 0 0 60.01 60.01 INRAVENOUS THERAPY 0 0 0 0 64.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 <td></td> <td>0</td> <td>0</td> <td>1</td> <td>0 0</td> <td>0</td> <td>F0 00</td>		0	0	1	0 0	0	F0 00
54.00 05400 RADI 0LOGY - DI AGNOSTI C 0		0			0 0	-	
57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.00 LABORATORY 0		0			0 0	-	
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.00 06000 LABORATORY 0		0			0 0	u u u u u u u u u u u u u u u u u u u	
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00 60.00 06000 LABORATORY 0		0			0 0	Ű	
60.00 06000 LABORATORY 0		0			0 0	u u u u u u u u u u u u u u u u u u u	
60.01 0KOOLOGY 0 <t< td=""><td></td><td>0</td><td></td><td></td><td>0 0</td><td>Ű</td><td></td></t<>		0			0 0	Ű	
60.02 06002 RADIATION ONCOLOGY 0		0			0 0	Ű	
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 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 67.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 69.00 CARDI AC REHAB 0 0 0 0 0 69.00 71.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL		0			0 0	Ű	
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69.00 69.01 06901 CARDI AC REHAB 0 0 0 0 69.00 71.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUSS CHARGED TO PATI ENTS 0 0 0 0 73.00 00.00 09000 CLI NI C 0 0 0 0 90.00 90.00 91.00 90.00 91.00 91.00 09100 EMERGENCY 0 0 0 0 92.01 92.01 09200 DSERVATI ON BEDS (DI STI NCT PART) 0 0 0 92.01 <t< td=""><td></td><td>0</td><td></td><td></td><td>0 0</td><td>Ű</td><td></td></t<>		0			0 0	Ű	
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 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 07300 DRUSS CHARGED TO PATI ENTS 0 0 0 0 0 73.00 0000 OP000 CLI NI C 0 0 0 0 73.00 01100 BERGENCY 0 0 0 0 90.00 91.00 90.00 O9200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.01 92.01 09200 DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 92.01 92.01 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>Ũ</td> <td></td>		0				Ũ	
69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69.00 69.01 06901 CARDI AC REHAB 0 0 0 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 0 09000 CLI NI C 0 0 0 0 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.01 92.01 92.01 92.01 92.		0				Ű	
69.01 06901 CARDI AC REHAB 0 0 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 01000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73.00 01000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73.00 010000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 010000 OPATI ENT SERVICE COST CENTERS 0 0 0 0 90.00 01100 D9100 EMERGENCY 0 0 0 0 91.00 02:00 D92ERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 92.00 02:01 DSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0		0				Ű	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 73.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 BAGERORY 0 0 0 0 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92.00 92.01 09201 DBSERVATI ON BEDS (DI STINCT PART) 0 0 0 92.01 01HER REIMBURSABLE COST CENTERS 0 0 0 0 92.01 0210 DBSERVATI ON BEDS (DI STINCT PART) 0 0 0 92.01 01HER REIMBURSABLE COST CENT		0				Ű	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 73.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 991.00 EMERGENCY 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 92.01 07HER REIMBURSABLE COST CENTERS UTHER UTHER REIMBURSABLE COST CENTERS 95.00 95.00 95.00 95.00		0				0	
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0		0				-	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 90.00 91.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 92.01 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 92.01 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00		0			0 0	-	
90.00 09000 CLINIC 0 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 92.00 92.01 OTHER REI MBURSABLE COST CENTERS 0 0 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00					<u> </u>		10100
91.00 09100 EMERGENCY 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 92.01 07HER REIMBURSABLE COST CENTERS 0 0 0 0 95.00		0	0		0 0	0	90.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.01 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	0		0 0	0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.01 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0			0	0	
95.00 09500 AMBULANCE SERVICES 95.00		0	0		0 0	0	
200.00 Total (lines 50 through 199) 0	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 PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 07/01/2020 To 06/30/2021		marad
		component	JON. 13-1011	10 00/ 30/ 2021	11/29/2021 7:	49 am
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical Education Cost	(sum of cols.	Outpatient Cost (sum of	(from Wkst. C,	(col. 5 ÷ col.	
	Education Cost	1, 2, 3, and 4)	cols. 2, 3,	8)	(COL 5 ÷ COL 7)	
		4)	and 4)	0)	(see	
					instructions)	
	4.00	5.00	6,00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		0100	0100	1100	0100	
50. 00 05000 OPERATI NG ROOM	0	0		0 110, 045, 872	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0		51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 30, 293, 068	0. 000000	54.00
57.00 05700 CT SCAN	0	0		0 42, 639, 412	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0 3, 873, 525	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 10, 645, 398	0.00000	59.00
60. 00 06000 LABORATORY	0	0		0 21, 304, 521		
60. 01 06001 ONCOLOGY	0	0		0 6, 307, 394	0.00000	60.01
60. 02 06002 RADIATION ONCOLOGY	0	0		0 0	0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 7, 909, 497		1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 11, 080, 961	0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 14, 672, 634		
69. 01 06901 CARDI AC REHAB	0	0		0 903, 448		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.00000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.00000	1
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 102, 429, 445	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	-	-		0 5 (0 5 5 0		
90. 00 09000 CLINIC	0	0		0 2, 569, 558		1
91.00 09100 EMERGENCY	0	0		0 78, 623, 830		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0		0 9, 259, 690		
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	l	0 0	0.00000	92.01
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	1					95.00
200.00 Total (lines 50 through 199)	0	0		0 452, 558, 253		200.00
200.00 10tal (11165 00 through 199)	I U	0	I	402, 000, 200	I	1200.00

Health Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-0011	Peri od:	Worksheet D	
THROUGH COSTS		Comment	OON 15 TO11	From 07/01/2020		
		component (CCN: 15-T011	To 06/30/2021	Date/Time Pre 11/29/2021 7:	
		Title	XVIII	Subprovider -	PPS	<u>47 ulli</u>
				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-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	57, 491		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	45, 075		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	93, 041		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	12, 829		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 060		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	102, 126		0 0	0	60.00
60. 01 06001 ONCOLOGY	0. 000000	573		0 0	0	60.01
60. 02 06002 RADI ATI ON ONCOLOGY	0. 000000	0		0 0	0	60.02
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	49, 950		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 339, 546		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	46, 655		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	320, 360		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0.000000	244		0 0	0	90.00
91. 00 09100 EMERGENCY	0.000000	78, 635		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0,000000	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS			·			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		3, 155, 585		0 0	0	200.00
	1 I.			1		

	Financial Systems MARION GENERAL H ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period: From 07/01/2020	u of Form CMS-2 Worksheet D-1	
		Title XVIII	To 06/30/2021 Hospi tal	Date/Time Prep 11/29/2021 7:4 PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		15, 122	1.
00	Inpatient days (including private room days, excluding swing-be	ed and newborn days)		15, 122	2.
00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). If you have only pr	ivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation be			11, 472	4
00	Total swing-bed SNF type inpatient days (including private room reporting period	n days) through Decembe	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	dava) through December	21 of the post	0	-
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 OF the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	4, 576	9
	newborn days) (see instructions)	0 1 0	, C		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructi		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	y (including private r	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		o room dave)	0	12
. 00	through December 31 of the cost reporting period	only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14
	Total nursery days (title V or XIX only)		5.	0	15
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions))		16, 425, 917	21
. 00	Swing-bed cost applicable to SNF type services through December	r 31 of the cost report	ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportir	ng period (line 6	0	23
00	x line 18) Swing had aget applicable to NE type completes through December	21 of the east report:	ng portion (Line		2
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)			0	24
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		16, 425, 917	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)		<u>J</u>	0	29
	Semi-private room charges (excluding swing-bed charges)	1		0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 minu	IS Line 33) (see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x line			0.00	
	Private room cost differential adjustment (line 3 x line 35)	· /		0.00	36
. 00	General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	16, 425, 917	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
_	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		-		
	Adjusted general inpatient routine service cost per diem (see i			1,086.23	
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			4, 970, 588 0	39 40
	Total Program general inpatient routine service cost (line 39	. ,		4, 970, 588	

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	MARION GENERA	Provider C	CN: 15-0011	Peri od:	u of Form CMS- Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Title	XVIII	Hospi tal	11/29/2021 7: PPS	49 añ
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4)	
2.00	NURSERY (title V & XIX only)	0	0				42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	4, 934, 602	3, 597	1, 371.	87 955	1, 310, 136	43.
4.00	CORONARY CARE UNIT	4, 934, 002	3, 377	1, 371.	755	1, 310, 130	44.
5.00	BURN INTENSIVE CARE UNIT						45.
6.00	SURGI CAL I NTENSI VE CARE UNI T						46.
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
8.00	Program inpatient ancillary service cost (Wks			20)		5, 446, 378	
9.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		11, 727, 102	49.
0. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	Wkst. D, sur	n of Parts I and	825, 631	50.
1 00)	tiont oncillor	, corrilado (fr	om Wkot D	num of Dorsto II	422 422	E1
51.00	Pass through costs applicable to Program inpa and IV)	atient anciiiar	y services (Tr	OM WKST. D, S	sum of Parts II	432, 432	51.
2.00	Total Program excludable cost (sum of lines {	50 and 51)				1, 258, 063	52.
53.00	Total Program inpatient operating cost exclud		lated, non-phy	sician anestl	netist, and	10, 469, 039	53.
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
4.00	Program di scharges					0	54.
5.00	Target amount per discharge					0.00	
6.00 7.00	Target amount (line 54 x line 55)	Line E2)	0				
7.00 B.00	Difference between adjusted inpatient operati Bonus payment (see instructions)	TThe 53)	0				
9.00	Lesser of lines 53/54 or 55 from the cost rep	ompounded by the	0.00				
0 00	market basket					0.00	
0.00 1.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than					Ū	
	amount (line 56), otherwise enter zero (see i	nstructions)			-		
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
0.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	
4.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reportin	n neriod (See	0	65.
5.00	instructions) (title XVIII only)				g period (See	0	00.
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line 6	5)(title XVI	I only). For	0	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	eporting period	o	67.
	(line 12 x line 19)	0					
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 0
59.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (line 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY		-	
0.00	Skilled nursing facility/other nursing facili	5)		70.
1.00 2.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /0 ÷ iine	2)			71.
3.00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73.
4.00	Total Program general inpatient routine servi	•	,				74.
5.00	Capital-related cost allocated to inpatient r 26, line 45)	routine service	costs (from W	orksheet B, I	Part II, column		75.
6.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
7.00	Program capital-related costs (line 9 x line	· ·					77.
B. 00	Inpatient routine service cost (line 74 minus	,	rouidor rooord				78.
9.00 0.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · ·		,	nus line 79)		79. 80.
1.00	Inpatient routine service cost per diem limit			(81.
2.00	Inpatient routine service cost limitation (li						82.
3.00	Reasonable inpatient routine service costs (see in		s)				83. 84.
4.00 5.00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84.
6.00	Total Program inpatient operating costs (sum	of lines 83 th					86.
7 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0.(50	1 07
	Total observation bed days (see instructions)					3, 650	
37.00 38.00	Adjusted general inpatient routine cost per o	diem (line ?7 ∸	line 2)			1, 086. 23	88

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-1			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2020	Worksheet D-1		
				To 06/30/2021	Date/Time Pre 11/29/2021 7:		
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital-related cost	2, 221, 043	16, 425, 917	0. 13521	6 3, 964, 740	536, 096	90.00	
91.00 Nursing School cost	0	16, 425, 917	0.00000	0 3, 964, 740	0	91.00	
92.00 Allied health cost	0	16, 425, 917	0.00000	0 3, 964, 740	0	92.00	
93.00 All other Medical Education	0	16, 425, 917	0. 00000	0 3, 964, 740	0	93.00	

00 Inpatient days (ncluding bing-back excluding swing-bed and observation bed days.) 2.688 2.888			From 07/01/2020	1	
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PART 1 - ALL PROVIDER COMPORENTS MARTLET DAYS - ALL PROVIDER COMPORENTS MARTLET DAYS - ALL PROVIDER COMPORENTS MARTLET DAYS - Composition Inpatient DAYS - Composition 0 - ALL PROVIDER COMPORENTS 0 - Private room days (excluding sing-bed and observation bed days). If you have only private room days, declain gasing-bed and subservation bed days) - 2,858 0 - Total sing-bed SF type inpatient days (including private room days) through becember 31 of the cost 0 0 - Total sing-bed SF type inpatient days (including private room days) through becember 31 of the cost 0 0 - Total sing-bed SF type inpatient days (including private room days) through becember 31 of the cost 0 0 - Total sing-bed SF type inpatient days (including private room days) 0 0 - Total sing-bed SF type inpatient days applicable to title WIII and y (including private room days) 0 1 - Total sing-bed SF type inpatient days applicable to title WIII and y (including private room days) 0 1 - Total sing-bed SF type inpatient days applicable to title WIII and y (including private room days) 0 1 - Total sing-bed SF type inpatient days applicable to title SVII		Title XVIII			.,
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6.00 Private room cost differential adjustment (line 3 x line 35) 0 36 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, more real differential (line 3, 799, 890) 37 PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 329, 56 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 329, 56 38 9.00 Program general inpatient routine service cost (line 9 x line 38) 2, 804, 042 39 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40			tions)		
7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 799, 890 27 minus line 36) 37.2 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 37.2 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 329.56 38.2 9.00 Program general inpatient routine service cost (line 9 x line 38) 2, 804, 042 39.0 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.2					
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 329.56 38. 9.00 Program general inpatient routine service cost (line 9 x line 38) 2, 804,042 39. 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.			fferential (Lino)		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 329.56 38. 9.00 Program general inpatient routine service cost (line 9 x line 38) 2, 804, 042 39. 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.		ost and private room cost dr		5, 777, 090	37.
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS8.00Adjusted general inpatient routine service cost per diem (see instructions)1, 329.569.00Program general inpatient routine service cost (line 9 x line 38)2, 804, 0420.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0					1
9.00Program general inpatient routine service cost (line 9 x line 38)2,804,042390.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040		ADJUSTMENTS			1
0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40	00 Adjusted general inpatient routine service cost per diem ((see instructions)			
1.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,804,042 41	5 51 11	o ,			40.

Health Financial Systems COMPUTATION OF INPATIENT OPERATIN	IG COST	MARION GENERAL	HOSPI TAL Provi der C	CN: 15-0011	In Lie Period:	u of Form CMS- Worksheet D-1	
				CCN: 15-T011	From 07/01/2020 To 06/30/2021	Date/Time Pre	epared:
			Ti tl e	e XVIII	Subprovider -	11/29/2021 7: PPS	49 am
Cost Center Descripti		Total npatient Costlr	Total npatient Days			Program Cost (col. 3 x col.	
	_	1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5. 00	
42.00 NURSERY (title V & XIX onl		0	0				42.0
Intensive Care Type Inpati 43.00 INTENSIVE CARE UNIT	ent Hospital Units	0	0	0.1		0	43.0
44. 00 CORONARY CARE UNIT		0	0	0.1			44.0
45.00 BURN INTENSIVE CARE UNIT							45.0
46.00 SURGICAL INTENSIVE CARE UN 47.00 OTHER SPECIAL CARE (SPECIF	1						46.0
Cost Center Descripti		I				1.00	47.0
48.00 Program inpatient ancillar	y service cost (Wkst	. D-3, col. 3,	line 200)			1.00 1,039,539	48.0
19.00 Total Program inpatient co	sts (sum of lines 41			ins)		3, 843, 581	
PASS THROUGH COST ADJUSTME 50.00 Pass through costs applica		ient routine se	ervices (from	Wkst. D, sur	n of Parts I and	361, 272	2 50.0
III) 51.00 Pass through costs applica	ble to Program inpat	ient ancillarv	services (fr	om Wkst D 4	sum of Parts II	86, 804	51.0
and IV)	0 1	5	30111003 (11	om witst. D, .			
52.00 Total Program excludable c 53.00 Total Program inpatient op			ated non-phy	sician anestl	netist and	448, 076 3, 395, 505	
medical education costs (1	<u>ine 49 minus line 52</u>					0,070,000	00.0
TARGET AMOUNT AND LIMIT CO 54.00 Program discharges	MPUTATION					0	54.0
55.00 Target amount per discharg						0.00	55.0
56.00 Target amount (line 54 x l 57.00 Difference between adjuste		a cost and tar	not omount (l	ino E4 minuc	line E2)		
8.00 Bonus payment (see instruc		g cost and tare	get amount (i	The 50 millios	TTHE 55)		
9.00 Lesser of lines 53/54 or 5	ompounded by the	0.00	59.0				
market basket 50.00 Lesser of lines 53/54 or 5	5 from prior year co	st report und:	ated by the m	arket basket		0.00	60.0
61.00 f line 53/54 is less than					the amount by	0.00	
which operating costs (lin			(lines 54 x	60), or 1% or	f the target		
amount (line 56), otherwis 62.00 Relief payment (see instru		structions)				c	62.0
63.00 Allowable Inpatient cost p	lus incentive paymen	t (see instruct	tions)			0	63.0
PROGRAM INPATIENT ROUTINE 64.00 Medicare swing-bed SNF inp		through Decemb	per 31 of the	cost reporti	ng period (See	C	64.0
instructions)(title XVIII	onl y)						
65.00 Medicare swing-bed SNF inp instructions)(title XVIII		arter becember	31 OF THE C	ως τεροτιτή	g period (see	C	65.0
66.00 Total Medicare swing-bed S CAH (see instructions)	NF inpatient routine	costs (line 64	1 plus line 6	5)(title XVI	I only). For	C	66.0
67.00 Title V or XIX swing-bed N	F inpatient routine	costs through [December 31 c	of the cost re	eporting period	0	67.0
(line 12 x line 19) 68.00 Title V or XIX swing-bed N	F inpatient routine	costs after Dec	cember 31 of	the cost rep	orting period	C	68.0
(line 13 x line 20)					5 1	C	
PART III - SKILLED NURSING	FACILITY, OTHER NUR	SING FACILITY,	AND ICF/IID	ONLY			, 09.0
70.00 Skilled nursing facility/c 71.00 Adjusted general inpatient)		70.0
71.00 Adjusted general inpatient 72.00 Program routine service co			ie 70 ÷ Title	2)			71.0
73.00 Medically necessary privat							73.0
74.00 Total Program general inpa 75.00 Capital-related cost alloc		•			Part II column		74.0
26, line 45)	•						
76.00 Per diem capital-related c 77.00 Program capital-related co							76.0
78.00 Inpatient routine service							78.0
9.00 Aggregate charges to benef		• •					79.0
30.00 Total Program routine serv 31.00 Inpatient routine service			st iimitation	i (iine /8 mii	ius i i ne 79)		80. C
32.00 Inpatient routine service	cost limitation (lin	e 9 x line 81)					82.0
33.00 Reasonable inpatient routi)				83.0
34.00 Program inpatient ancillar 35.00 Utilization review - physi		,	5)				84. C
36.00 Total Program inpatient op	erating costs (sum o	flines 83 thro					86.0
PART IV - COMPUTATION OF 0 87.00 Total observation bed days		THROUGH COST				C	07 0
87.00 Total observation bed days 88.00 Adjusted general inpatient	. ,	em (line 27 ÷ l	ine 2)) 87.0) 88.0
89.00 Observation bed cost (line	•	•	-				89.0

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2020	Worksheet D-1	
		Component (Component CCN: 15-T011		Date/Time Prep 11/29/2021 7:4	pared: 49 am
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	489, 571	3, 799, 890	0. 12883	8 0	0	90.00
91.00 Nursing School cost	0	3, 799, 890	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 799, 890	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 799, 890	0.00000	0 0	0	93.00

	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period: From 07/01/2020	u of Form CMS-2 Worksheet D-1	
		THE MAY	To 06/30/2021	Date/Time Pre 11/29/2021 7:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(c. oveluding newborn)		15, 122	1 1
00	Inpatient days (including private room days, excluding swing-			15, 122	
00	Private room days (excluding swing-bed and observation bed da	ıys). If you have only pr	ivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		11, 472	
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5
20	reporting period		21 -6	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	on days) after becenber	31 OF THE COST	0	6
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roc	m davs) after December 3	1 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	in days) ar ter becomber e		Ũ	
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	418	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	room days)	0	10
	through December 31 of the cost reporting period (see instruc			_	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, et al. 2010)		room days) after	0	1
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	1:
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including privat	a room dave)	0	1:
. 00	after December 31 of the cost reporting period (if calendar y			0	
. 00	Medically necessary private room days applicable to the Progr			-	14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 570 0	
. 00	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction)		16, 425, 917	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22
. 00	5×1 ine 17)	21 of the east reporting	a pariod (line (0	23
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	ST OF THE COST TEPOLITY	ig period (Title o	0	2.
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 16, 425, 917	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			10, 423, 717	2
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)		28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	20
	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) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00 0.00	
. 00	Average per diem private room cost differential (line 34 x li			0.00	35
. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line)	0 16 425 917	36
. 00	27 minus line 36)	and private room cost di	rierentiar (rine	16, 425, 917	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 086. 23	38
	Program general inpatient routine service cost (line 9 x line			454, 044	
. 00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40
. 00	Total Program general inpatient routine service cost (line 39	7 + line 40)		454, 044	4'

	Financial Systems ATION OF INPATIENT OPERATING COST	MARION GENERAL	HOSPI TAL	:N: 15-0011	In Lie Period:	u of Form CMS- Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:	
	Cost Center Description	Total Inpatient Costlu 1.00	Total	e XIX Average Per Diem (col. 1 col. 2) 3.00		Cost Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)	2, 296, 048	1, 570	1, 462. 4		0	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	4, 934, 602	3, 597	1, 371.8	37 0	0	43.00
43.00	CORONARY CARE UNIT	4,934,002	3, 397	1, 3/1. c	0	0	43.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
48.00	Program inpatient ancillary service cost (Wks					216, 983	•
49.00	Total Program inpatient costs (sum of lines 4	1 through 48)(s	ee instructio	ns)		671, 027	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tient routine s	ervices (from	Wkst D sum	of Parts L and	0	50.00
00.00				intot: b, sui		0	00.00
51.00	Pass through costs applicable to Program inpa	ntient ancillary	services (fr	om Wkst. D, s	um of Parts II	0	51.00
52.00	and IV)	0 and E1)				0	52.00
52.00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		ated non-phy	sician anesth	etist and	0	
	medical education costs (line 49 minus line 5						
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 55.00	Program di scharges					0 0.00	
56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	•
57.00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	•
58.00	Bonus payment (see instructions)		0				
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	mpounded by the	0.00	59.00			
60.00	Lesser of lines 53/54 or 55 from prior year of	ost report, upd	ated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines				the amount by	0	•
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						1
64.00	Medicare swing-bed SNF inpatient routine cost	s through Decem	ber 31 of the	cost reporti	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decembe	r 31 of the c	ost reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	0	67.00
07.00	(line 12 x line 19)	0				0	
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	rting period	0	68.00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	outine costs (L	ine 67 + line	68)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU			,			
70.00	Skilled nursing facility/other nursing facili						70.00
71.00 72.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ne 70 ÷ líne .	2)			71.00
73.00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine servi	0	•				74.00
75.00	Capital-related cost allocated to inpatient r	routine service	costs (from W	orksheet B, P	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess						79.00
80.00 81.00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		SUITMITATION	(IINE /8 MIN	us i ne 79)		80.00 81.00
82.00	Inpatient routine service cost limitation (li						82.00
83.00	Reasonable inpatient routine service costs (s	ee instructions					83.00
84.00	Program inpatient ancillary services (see ins		c)				84.00
85.00 86.00	Utilization review - physician compensation (Total Program inpatient operating costs (sum						85.00 86.00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						00.00
87.00	Total observation bed days (see instructions)					3, 650	
	Adjusted general inpatient routine cost per c	liom (lino 27 ·	$1 i n \circ 2$			1,086.23	1 88 00
88.00	Observation bed cost (line 87 x line 88) (see		TTTTE Z)			3, 964, 740	

Health Financial Systems	AL HOSPI TAL		In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:	pared: 49 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 221, 043	16, 425, 917	0. 13521	6 3, 964, 740	536, 096	90.00
91.00 Nursing School cost	0	16, 425, 917	0.00000	0 3, 964, 740	0	91.00
92.00 Allied health cost	0	16, 425, 917	0.00000	0 3, 964, 740	0	92.00
93.00 All other Medical Education	0	16, 425, 917	0.00000	0 3, 964, 740	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T011	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:4	
		Title XIX	Subprovider - IRF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		I		
	I NPATI ENT DAYS		1		
	Inpatient days (including private room days and swing-bed day			2, 858	
. 00	Inpatient days (including private room days, excluding swing-		· · · · · · · · · · · · · · · · · · ·	2, 858	2.
. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	Ivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation I	bed days)		2, 858	4.
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0	5.
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	am daya) through December	21 of the east	0	-
00	Total swing-bed NF type inpatient days (including private roor reporting period	on days) through becenber	31 OF the COST	0	7.
. 00	Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)	5 /			
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	11	9
	newborn days) (see instructions)				10
D. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		oom days)	0	10
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, e			-	
2. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	e room days)	0	12
	through December 31 of the cost reporting period				
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary			0	13
1.00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	i din (okoi dai ng olining boa	uujo)	1, 570	
5.00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT		1		
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 c	f the cost	0.00	17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
0.00	reporting period			0.00	
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.
1.00	reporting period Total general inpatient routine service cost (see instruction	ns)		3, 799, 890	21
	Swing-bed cost applicable to SNF type services through Decemi		ing period (line	0	22
	5 x line 17)			-	
3.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	g period (line 6	0	23
	x line 18)			0	24
4.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ng period (inne	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)	1 3			
	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 799, 890	27
3. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	od and obsorvation bod ch	argos)	0	28
	Private room charges (excluding swing-bed charges)		ai 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	31
	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 Average per diem private room cost differential (line 34 x li		tions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line)	3, 799, 890	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
3.00	Adjusted general inpatient routine service cost per diem (see			1, 329. 56	
				14, 625	39
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Prog			023	

	Financial Systems TION OF INPATIENT OPERATING COST	MARION GENERAL		CN: 15-0011	In Lie Period:	eu of Form CMS- Worksheet D-1	
				CCN: 15-T011	From 07/01/2020 To 06/30/2021	Date/Time Pre	epare
			Titl	e XIX	Subprovider -	11/29/2021 7: Cost	49 a
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient CostIn		col. 2)		(col. 3 x col. 4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00) 42.
l	Intensive Care Type Inpatient Hospital Units			-			
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.	00 0	C) 43. 44.
	BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1.00	5 48.
. 00 🛛	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		19, 611	
0. 00	Pass through costs applicable to Program inp	atient routine se	rvices (from	n Wkst. D, su	m of Parts I and	C	50.
	III) Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	c c) 51.
	and IV)	EQ and E1)				c c	52
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ted, non-phy	sician anest	hetist, and		
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00 [Program di scharges					C	54
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and targ	et amount (I	ine 56 minus	line 53)		
	Bonus payment (see instructions)	ing obse and earg			11110 00)	0	
	Lesser of lines 53/54 or 55 from the cost re	porting period en	ding 1996, ι	updated and c	ompounded by the	0.00) 59
	market basket Lesser of lines 53/54 or 55 from prior year	cost roport unda	tod by the m	arkat backat		0.00	60
	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)				
F	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	er 31 of the	e cost report	ing period (See	C	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the d	cost reportin	g period (See	C	65
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 6	5)(title XVI	II only). For	c	66
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through D	ecember 31 d	of the cost r	eporting period	c c	67
	(line 12 x line 19)	0					
	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 of	the cost rep	orting period	C	68
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					C	69
	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c	ost per diem (lin	e 70 ÷ line	2)			71
	Program routine service cost (line 9 x line		lino 14 v !!	no 2E)			72
	Medically necessary private room cost applic Total Program general inpatient routine serv	υ,					74
. 00	Capital -related cost allocated to inpatient 26, line 45)	•			Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li						76
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77
	Aggregate charges to beneficiaries for exces		vi der record	ls)			79
	Total Program routine service costs for comp		t limitatior	n (line 78 mi	nus line 79)		80
	Inpatient routine service cost per diem limi						81
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
	Program inpatient ancillary services (see in						84
1	Utilization review - physician compensation						85
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugh 85)				86
	Total observation bed days (see instructions					C	87
3. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			0.00	88
	Observation bed cost (line 87 x line 88) (se	e instructions)				I C) 89

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2020	Worksheet D-1	
		Component (To 06/30/2021		pared: 49 am
		Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				,	4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	489, 571	3, 799, 890	0. 12883	8 0	0	90.00
91.00 Nursing School cost	0	3, 799, 890	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 799, 890	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 799, 890			0	93.00

Health Financial Systems MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Peri od:	Worksheet D-3	
			From 07/01/2020		
			To 06/30/2021	Date/Time Pre 11/29/2021 7:	
	Ti tl o	XVIII	Hospi tal	PPS	49 dili
Cost Center Description	II LI E	Ratio of Cos		Inpati ent	
Cost center bescription		To Charges	Program	Program Costs	
		TO charges		$(col. 1 \times col.$	
			chai yes	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS			5, 677, 961		30.00
31.00 03100 I NTENSI VE CARE UNI T			2, 091, 318		31.00
40. 00 04000 SUBPROVI DER - I PF			2,071,010		40.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 1390	7, 993, 681	1, 111, 154	50.00
51. 00 05100 RECOVERY ROOM		0.0000		0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2876		231, 582	1
57. 00 05700 CT SCAN		0. 0359		105, 975	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2156		27, 071	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 2156		325, 048	1
60. 00 06000 LABORATORY		0. 3271			60.00
		0. 3793			
				4, 303	
60. 02 O6002 RADIATION ONCOLOGY		0.0000		0	60.02
64.00 06400 I NTRAVENOUS THERAPY		0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 5125		336, 326	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3592		320, 394	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1648		287, 796	69.00
69. 01 06901 CARDI AC REHAB		0. 5944		0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000	0 00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2014	58 5, 160, 551	1, 039, 634	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 7641		2, 736	90.00
91. 00 09100 EMERGENCY		0. 1499		678, 398	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4281		0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	0 00	0	92.01
OTHER REIMBURSABLE COST CENTERS			-1		
95. 00 09500 AMBULANCE SERVI CES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			27, 542, 535	5, 446, 378	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			27, 542, 535		202.00

Health Financial Systems MARION GEN	IERAL HOSPI TAL			u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T011	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:	
	Titl€	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	i	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	_
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			1
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
40. 00 04000 SUBPROVIDER - IPF			0 7/0 000		40.00
41. 00 04100 SUBPROVIDER - IRF			2, 768, 009		41.00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0 1200	DA 57.401	7 001	
50. 00 05000 OPERATING ROOM		0. 1390		7, 991	
51.00 05100 RECOVERY ROOM		0.0000		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2876			
57. 00 05700 CT SCAN		0.0359		3, 349	
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0. 2156			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3271			
60. 00 06000 LABORATORY		0.5780			
60. 01 06001 0NC0L0GY		0. 3793			
60. 02 06002 RADI ATI ON ONCOLOGY		0.0000			
64. 00 06400 I NTRAVENOUS THERAPY		0.0000		-	
65. 00 06500 RESPI RATORY THERAPY		0. 5125			
66. 00 06600 PHYSI CAL THERAPY		0.3592			
69. 00 06900 ELECTROCARDI OLOGY		0. 1648			
69. 01 06901 CARDI AC REHAB		0. 5944			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.0000			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2014	58 320, 360	64, 539	73.00
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C		0. 7641	23 244	186	90.00
91. 00 09100 EMERGENCY		0. 7841			
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 4281		-	
072. 01 09201/08SERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0.0000	00 0	L	1 92.01
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98	3)		3, 155, 585	1, 039, 539	
201.00 Less PBP Clinic Laboratory Services-Program only cl			3, 155, 565		200.00
	aiyes (iiiie oi)		-		201.00
202.00 Net charges (line 200 minus line 201)		1	3, 155, 585	I	1202. UU

	ON GENERAL HOSPITAL			u of Form CMS-	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-0011	Period: From 07/01/2020	Worksheet D-3	
			To 06/30/2021	Date/Time Pre	nared
			10 00/ 30/ 2021	11/29/2021 7:	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1	
30. 00 03000 ADULTS & PEDI ATRI CS			426, 911		30.0
31. 00 03100 INTENSIVE CARE UNIT			97, 156		31.0
IO. 00 04000 SUBPROVI DER – I PF			0		40.0
1. 00 04100 SUBPROVIDER - IRF			0		41.0
2. 00 04200 SUBPROVI DER			0		42.0
3. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM		0.13900		60, 737	50.0
51.00 05100 RECOVERY ROOM		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2876	79 36, 883	10, 610	54.0
57. 00 05700 CT SCAN		0.03599	92 112, 602	4, 053	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2156	17 4,002	863	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 32718	36 1, 244	407	59.0
0. 00 06000 LABORATORY		0.57803	37 72, 806	42, 085	60.0
50. 01 06001 ONCOLOGY		0. 37932	24 0	0	60.0
0. 02 06002 RADIATION ONCOLOGY		0.0000	0 00	0	60.0
4. 00 06400 I NTRAVENOUS THERAPY		0.0000	0 00	0	64.0
5. 00 06500 RESPI RATORY THERAPY		0.51250	66 34, 472	17,669	65.0
6. 00 06600 PHYSI CAL THERAPY		0.35923	31 18, 284	6, 568	66.0
9. 00 06900 ELECTROCARDI OLOGY		0. 16488			
9. 01 06901 CARDI AC REHAB		0. 59449		0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	71.0
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2014		0	
OUTPATI ENT SERVICE COST CENTERS		0.2014	172, 750	54, 042	1 / 5. 0
0. 00 09000 CLINIC		0. 76412	23 0	0	90.0
01.00 09100 EMERGENCY		0. 14998			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4281			92.0
22.01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 00000		0	92.0
OTHER REIMBURSABLE COST CENTERS		0.00000	0	0	, 2.0
25. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through	ough 98)		1, 145, 267	216, 983	
201.00 Less PBP Clinic Laboratory Services-Program of			1, 143, 207	210,703	200.0
	my charges (The OT)		1, 145, 267		201.0

Health Financial Systems	MARION GENERAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Peri od:	Worksheet D-3	1
	Component	CCN: 15-T011	From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:	epared: 49 am
	Ti tI	e XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
40. 00 04000 SUBPROVIDER - IPF					40.00
41.00 04100 SUBPROVIDER - IRF			14, 190		41.00
42.00 04200 SUBPROVI DER					42.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.1000			
50. 00 05000 OPERATING ROOM		0. 1390			
51.00 O5100 RECOVERY ROOM		0.0000			
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2876		-	
57.00 05700 CT SCAN		0.0359		-	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2156		-	
59.00 05900 CARDIAC CATHETERIZATION		0. 3271		-	
60. 00 06000 LABORATORY		0. 5780			
60. 01 06001 0NC0L0GY		0. 3793		-	
60. 02 06002 RADI ATI ON ONCOLOGY		0.0000		0	
64.00 06400 I NTRAVENOUS THERAPY		0.0000		-	
65. 00 06500 RESPI RATORY THERAPY		0. 5125		-	
66. 00 06600 PHYSI CAL THERAPY		0. 3592			
69.00 06900 ELECTROCARDI OLOGY		0. 1648		-	
69. 01 06901 CARDI AC REHAB		0. 5944		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		-	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2014	58 754	152	73.00
OUTPATIENT SERVICE COST CENTERS				-	
90. 00 09000 CLINIC		0.7641		-	
91.00 09100 EMERGENCY		0. 1499		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4281			
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	00 0	0	92.01
		-			
95. 00 09500 AMBULANCE SERVICES	there ===================================		14.0/7	4	95.00
200.00 Total (sum of lines 50 through 94 and 96			14, 067	4, 986	200.00
201.00 Less PBP Clinic Laboratory Services-Progra	am only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	14, 067		202.00

	Financial Systems MARION GENERAL H ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Peri od: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre	
				11/29/2021 7:	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00 1.01	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	na prior to October 1 (See	0 3, 084, 260	
1. 02	DRG amounts other than outlier payments for discharges occurrin		8, 913, 569	1. 02	
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	prior to October	0	1. 03	
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	r di scharges occurri ng	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	-		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (s			7, 978	
2.04 3.00	Outlier payments for discharges occurring on or after October Managed Care Simulated Payments	(see instructions)		56, 071 0	2.04 3.00
4.00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	ting period (see instru	ictions)	99.59	4.00
5.00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e) $$			0.00	6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified under 4 ACA § 5503 reduction amount to the IME cap as specified under 4			0.00 0.00	7.00 7.01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.75 (b), 413.75			0.00	8.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot report straddles July 1, 2011, see instructions.	ts under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slot under § 5506 of ACA. (see instructions)	ts from a closed teachi	ng hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)			0.00	
10.00	FTE count for allopathic and osteopathic programs in the currer FTE count for residents in dental and podiatric programs.	nt year from your recor	ds	0.00	10.00
12.00 13.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	r ended on or after Sep	otember 30, 1997,		14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program				16.00
17.00 18.00	Adjustment for residents displaced by program or hospital closu Adjusted rolling average FTE count	ure			17.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.00000	21.00
22.00	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22.01
23.00	Number of additional allopathic and osteopathic IME FTE resider $(f)(1)(iv)(C)$.	nt cap slots under 42 (FR 412.105		23.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	ower of line 23 or line	e 24 (see		24.00 25.00
26.00	instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	
27.00 28.00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0	27.00
28.00	IME add-on adjustment amount - Managed Care (see instructions)			0	
29.00 29.00 29.01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01))		0	29.00
	Di sproporti onate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	tient days (see instruc	tions)	5.24	
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			25. 49 30. 73	31.00 32.00
32.00 33.00	Allowable disproportionate share percentage (see instructions)				32.00
	In the second of			17.37	1 20.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Pre 11/29/2021 7:4	
		Title XVIII	Hospi tal	PPS	49 alli
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		8, 350, 599, 096	8, 290, 014, 521	35.0
5. 01	Factor 3 (see instructions)		0. 000307154	0. 000197803	35.0
5. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	e 2, 564, 920	1, 639, 791	35.0
	instructions)				
5.03	Pro rata share of the hospital uncompensated care payment amo		644, 734	1, 226, 473	
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		1, 871, 207		36.0
0 00	Additional payment for high percentage of ESRD beneficiary di		gn 46) 0		40.0
0. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6 instructions)	584 and 685. (See	0		40.0
			Before 1/1	On/After 1/1	
			1.00	1.01	
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0	0	41.0
	instructions)				
1.01	Total ESRD Medicare covered and paid discharges excluding MS-	-DRGs 652, 682, 683, 684	0	0	41.0
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.0
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (see	0		43.0
4.00	instructions) Ratio of average length of stay to one week (line 43 divided	by Line 41 divided by 7	0.000000		44.0
4.00	days)	by The 41 divided by 7	0.00000		44.0
5.00	Average weekly cost for dialysis treatments (see instructions	5)	0.00	0.00	45. C
6.00	Total additional payment (line 45 times line 44 times line 41	<i>·</i>	0		46.0
7.00	Subtotal (see instructions)	,	14, 370, 106		47.0
8.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	13, 383, 221		48. C
	only. (see instructions)				
				Amount	
		<u>`````````````````````````````````````</u>		1.00	
	Total payment for inpatient operating costs (see instructions			14, 370, 106	49.0
0.00 1.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar Exception payment for inpatient program capital (Wkst. L, Pt.			925, 592 0	50. C
2.00	Direct graduate medical education payment (from Wkst. E, Pt.			0	52.0
3.00	Nursing and Allied Health Managed Care payment			0	53.0
4.00	Special add-on payments for new technologies			34, 206	
4.01	Islet isolation add-on payment			0	54.0
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	69)		0	55.0
6.00	Cost of physicians' services in a teaching hospital (see intr	ructions)		0	56. (
7.00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57.0
8.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58.
9.00	Total (sum of amounts on lines 49 through 58)			15, 329, 904	
0.00	Primary payer payments	Line (0)		41,906	60.
1.00 2.00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries			15, 287, 998 1, 503, 164	
2.00 3.00	Coinsurance billed to program beneficiaries			7, 791	
4.00	Allowable bad debts (see instructions)			93, 947	
5.00	Adjusted reimbursable bad debts (see instructions)			61, 066	65.
6.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		24, 860	66.
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	·		13, 838, 109	67.
7.00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	68.
7.00 8.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	69.
	outries payments reconcritation (sum of rifles 43, 45 and 46).			0	70.
8.00 9.00 0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		instructions)	0	70.
8.00 9.00 0.00 0.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see			1 70
8.00 9.00 0.00 0.50 0.87	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	tration) adjustment (see		0	70.
8.00 9.00 0.00 0.50 0.87 0.88	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0 0	70.
8.00 9.00 0.00 0.50 0.87 0.88 0.89	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst			0	70. 70.
B. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 70. 70.
B. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0 0 0	70. 70. 70. 70.
B. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0 0 0	70. 70. 70. 70. 70.
B. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0 0 0	70. 70. 70. 70. 70. 70.

COULA	Financial Systems MARION GENERAL TION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0011	Peri od:	u of Form CMS-2 Worksheet E	
				From 07/01/2020 To 06/30/2021	Part A Date/Time Pre	pared
					11/29/2021 7:	49 am
		litle	XVIII	Hospi tal	PPS	
			FFY	(уууу) 0	<u>Amount</u> 1.00	
0.96 1	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.9
	the corresponding federal year for the period prior to 10/1)			-	-	
	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.9
	the corresponding federal year for the period ending on or af	fter 10/1)			_	
1	Low Volume Payment-3				0	
	HAC adjustment amount (see instructions)	(0 % 70)			50, 296	
	Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions)	69 & 70)			13, 827, 776 0	
	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM pass-throughs				0	71.0
	Interim payments				13, 935, 426	
	Interim payments-PARHM					72.0
3.00	Tentative settlement (for contractor use only)				0	73.0
	Tentative settlement-PARHM (for contractor use only)					73.0
	Balance due provider/program (line 71 minus lines 71.01, 71.0	02, 72, and			-107, 650	74.0
1	73) Palanaa dua providar (program DADUM (ass. i patruationa)					74.0
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nco with			244 024	74. C
	CMS Pub. 15-2, chapter 1, §115.2	ince with			366, 824	/5.0
	O BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.0
1	olus 2.04 (see instructions)					
	Capital outlier from Wkst. L, Pt. I, line 2				0	91. (
	Operating outlier reconciliation adjustment amount (see instr				0	92. (
	Capital outlier reconciliation adjustment amount (see instruc				0	93.0
	The rate used to calculate the time value of money (see instr Time value of money for energian average (and instructions)				0.00	
	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc				0	95. 0 96. 0
0.00	The value of money for capital related expenses (see this fue		1	Prior to 10/1		70.0
1				1.00	2.00	
L L	ISP Bonus Payment Amount			1.00	2.00	
00. 00	HSP bonus amount (see instructions)			1.00		100. 0
ا 00.00 ا	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	
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00.001 F 01.001 02.001 02.001 03.001 04.001 00.001 01.001 02.001 02.001 02.001 02.001 02.001 02.001 03.001 04.001 05.001 05.001 05.001 05.001 00.	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 factor (see instructions) HRR 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 pe Century Cures Act? Enter "Y" for yes or "N" for no. 20 Sost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) 20 Case-mix adjustment factor (see instructions) 20 Computation of Demonstration Target Amount Limitation (N/A in 20 period) Medicare target amount 20 Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare part A Inpatient Reimbursement 21 Program reimbursement under the §410A Demonstration (see instructions) 22 Reserved for future use	s) ration) Adju rriod under t ne 49) first year first year ructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.000000000 0 0.0000 0	101. (102. (103. (103. (200. (200. (202. (203. (204. (205. (206. (206. (206. (207. (208. (209. (209. (209. (200. (
00.001 H 01.001 02.001 03.001 04.001 04.001 00.001 01.001 02.001 02.001 02.001 03.001 03.001 04.001 05.001 05.001 06.001 07.001 08.001 01.	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 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 pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment 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)	s) ration) Adju rriod under t ne 49) first year first year ructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.000000000 0 0.0000 0	101. (102. (103. (103. (200. (200. (202. (203. (204. (205. (204. (205. (206. (206. (207. (208. (209. (209. (209. (200. ()))))))))))))))))))))))))))))))))))
00. 00 01. 00 02. 00 03. 00 04. 00 04. 00 00. 00 01. 00 02. 00 01. 00 02. 00 02. 00 03. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 11. 00 02. 00 04. 00 05. 00 07. 00 07. 00 08. 00 09. 00 09. 00 00. 00 00. 00 00. 0	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 factor (see instructions) 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 pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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) Comparision of PPS versus Cost Reimbursement	s) ration) Adju eriod under 1 ne 49) first year first year ructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.000000000 0 0.0000 0	101. (102. (103. (104. (200. (201. (202. (203. (205. (205. (207. (208. (209. (209. (209. (201. () 201. () 201. ()
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 00. 00 01. 00 02. 00 03. 00 03. 00 04. 00 05. 00 05. 00 06. 00 07. 00 08. 00 09. 00 10. 00 11. 00 11. 00 12. 00	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 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 pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 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) Mdjustment 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 Total adjustment to Medicare Part A IPPS payments (from line	s) ration) Adju eriod under 1 ne 49) first year first year ructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101. (102. (103. (104. (200. (201. (202. (203. (203. (204. (205. (205. (206. (206. (209. (201. (20
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00	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 factor (see instructions) 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 pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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) Comparision of PPS versus Cost Reimbursement	ration) Adju riod under t e 49) first year ructions) line 59)	of the curre	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0 0	101. (102. (103. (104. (200. (201. (202. (203. (203. (205. (206. (206. (206. (207. (208. (

	Financial Systems LUME CALCULATION EXHIBIT 4		MARION GENERA	Provider CO	1	Period: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 11/29/2021 7:4	t 4 pare
		W/S E, Part A	Amounts (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	47 0
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
00	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00	1
D1	payments DRG amounts other than outlier	1. 01	3, 084, 260	0		-	3, 084, 260	
12	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	8, 913, 569	0		8, 913, 569	8, 913, 569	
	payments for discharges occurring on or after October 1							
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	(D	0	1
)4	DRG for Federal specific operating payment for Model 4 BPCl occurring on or after	1.04	0	0		0	0	1
00	October 1 Outlier payments for discharges (see instructions)	2.00						2
)1	Outlier payments for	2.02	0	0		0 0	0	2
2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2.03	7, 978	0	7, 978	3	7, 978	2
)3	October 1 (see instructions) Outlier payments for discharges occurring on or	2. 04	56, 071	0		56, 071	56, 071	2
	after October 1 (see instructions)							
0	Operating outlier	2.01	0	0	(0 0	0	
0	reconciliation Managed care simulated payments	3.00	О	0	(o o	0	4
	Indirect Medical Education Adju		· · ·					
0	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 000000	0. 000000	0. 000000	0. 000000 0 0. 000000	0	6
1	instructions) IME payment adjustment for managed care (see	22.01	O	0	(o o	0	e
	instructions) Indirect Medical Education Adju	ustment for the	e Add-on for Sec	tion 422 of t	he MMA			1
0	IME payment adjustment factor	27.00	0.000000	0. 000000		0. 000000		7
0	(see instructions) IME adjustment (see instructions)	28.00	О	0	(o o	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	(0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0	(0 0	0	Ģ
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							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1457	0. 1457	0. 145	7 0. 1457		10
00	Disproportionate share adjustment (see instructions)	34.00	437, 021	0			437, 021	
01	Uncompensated care payments Additional payment for high per	36.00 centage of ESI	1,871,207 D beneficiary (0 li scharges	644, 734	4 1, 226, 473	1, 871, 207	11
00	Total ESRD additional payment (see instructions)	46.00	0	0	(0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	14, 370, 106 0	0 0	3, 849, 310 (5 10, 520, 790 D 0	14, 370, 106 0	
00	(see instructions) Total payment for inpatient operating costs (see	49.00	14, 370, 106	0	3, 849, 310	5 10, 520, 790	14, 370, 106	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	925, 592	0	1, 169, 500	-243, 908	925, 592	16

	Financial Systems		MARION GENERA				eu of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC		Period: From 07/01/2020 To 06/30/2021		pared:
				Title	XVIII	Hospi tal	PPS	ry am
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	34, 206	0		0 34, 206	34, 206	17.00
17.01	Net organ aquisition cost							17.0
17.02	Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.02
18.00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		0	0		0 0	0	18.00
19.00	instructions) SUBTOTAL			0	5, 018, 81	6 10, 311, 088	15, 329, 904	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 BPCl Capital DRG other than outlier		905, 258 0	0 0	1, 145, 47	0 -240, 212 0 0		20. 00 20. 01
21.00	Capital DRG outlier payments	2.00	20, 334	0	24, 03	0 -3, 696	20, 334	21.00
21.00	Model 4 BPCI Capital DRG outlier payments	2.00	20, 334	0	24, 03	0 -3, 090		21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	_	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0 0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. 0
26.00	Total prospective capital payments (see instructions)	12.00	925, 592	0	1, 169, 50	0 -243, 908	925, 592	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor	0	1.00	2.00	0, 00000			27.0
28.00	Low volume adjustment detor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0	0	
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29.0
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

	Financial Systems TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	MARION GENERA		CN: 15-0011	Peri od:	eu of Form CMS-: Worksheet E	2332-10
					From 07/01/2020 To 06/30/2021		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1.00 1.01	3, 084, 260			3, 084, 260	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1.02	8, 913, 569		8, 913, 569	8, 913, 569	1. 02
1.03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	7, 978	7, 97		7, 978	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	56, 071		56, 071	56, 071	2.03
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2.01 3.00	0		0 0 0 0	0	
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0 0. 000000		5.00
6.00	(see instructions) IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment (see first detroits) instructions)	22.00	0		0 0	0	1
	Indirect Medical Education Adjustment for the		ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0 0.000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0	
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	0		0 0 0 0	0	
	Disproportionate Share Adjustment				-	1	-
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1457	0. 145	7 0. 1457		10.00
11.00	Disproportionate share adjustment (see i nstructions)	34.00	437, 021	112, 34	4 324, 677	437, 021	11.00
11. 01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	1, 871, 207	644, 73	4 1, 226, 473	1, 871, 207	11.01
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH	47.00 48.00	14, 370, 106 0	3, 849, 31	6 10, 520, 790 0 0	14, 370, 106 0	
	and MDH, small rural hospitals only.) (see instructions)						
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14, 370, 106				
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	925, 592				
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	34, 206		0 34, 206		17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
19.00	SUBTOTAL			5, 018, 81	6 10, 311, 088	15, 329, 904	19.00

Heal th Fi	nancial Systems	MARION GENER	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPI TAL	ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00 Ca	pital DRG other than outlier	1.00	905, 258	1, 145, 4	70 -240, 212	905, 258	20.00
20.01 Mo	del 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00 Ca	pital DRG outlier payments	2.00	20, 334	24, 0	30 - 3, 696	20, 334	21.00
	odel 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
	ndirect medical education percentage (see	5.00	0.0000	0.00	0.000	_	22.00
	istructions)						
	direct medical education adjustment (see structions)	6.00	0		0 0	0	23.00
24.00 AI	lowable disproportionate share percentage see instructions)	10.00	0.0000	0.00	0.000		24.00
25.00 Di	sproportionate share adjustment (see istructions)	11.00	0		0 0	0	25.00
26.00 To	otal prospective capital payments (see istructions)	12.00	925, 592	1, 169, 5	-243, 908	925, 592	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1,00	2,00	3.00	4.00	
27.00		-					27.00
28.00 Lo	w volume adjustment prior to October 1	70, 96	0		0	0	28.00
	w volume adjustment on or after October 1	70, 97	0		0	0	29.00
	/BP payment adjustment (see instructions)	70.93	59, 831	16, 3	47 43, 484	59, 831	
	/BP payment adjustment for HSP bonus	70, 90	0	1070	0 0	0	1
	ayment (see instructions)	, , .			0		00.01
	R adjustment (see instructions)	70, 94	-19, 868	-5, 5	52 -14, 316	-19, 868	31.00
	RR adjustment for HSP bonus payment (see	70, 91	0	-1	0 0	0	1
	nstructions)						
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	NC Reduction Program adjustment (see Astructions)	70. 99		50, 2	96 0	50, 296	32.00
100.00 Tr	ansfer HAC Reduction Program adjustment to sst. E, Pt. A.		Y				100. 00

CALCUL	Financial Systems MARION GENERAL HOSP ATION OF REIMBURSEMENT SETTLEMENT Pro	ovider CCN: 15-0011	Period: From 07/01/2020	u of Form CMS-2 Worksheet E Part B	
			To 06/30/2021	Date/Time Pre	
		Title XVIII	Hospi tal	11/29/2021 7: PPS	49 am
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			21, 571	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	s)		17, 178, 793	
3.00 4.00	OPPS payments Outlier payment (see instructions)			15, 115, 839 81, 485	
4.00	Outlier reconciliation amount (see instructions)			01,403	
5.00	Enter the hospital specific payment to cost ratio (see instructio	ns)		0.000	
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00	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	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 21, 571	10.0 11.0
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			21, 371	11.0
	Reasonabl e charges				
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	60)		43, 260 0	12.00
14.00	Total reasonable charges (sum of lines 12 and 13)	07)		43, 260	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for paym Amounts that would have been realized from patients liable for pa			0	
16. 00	had such payment been made in accordance with 42 CFR §413.13(e)	yment for services of	n a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	•
18.00	Total customary charges (see instructions)	£ 1: 10	11) (43, 260	
19.00	Excess of customary charges over reasonable cost (complete only i instructions)	T IINE 18 exceeds II	ne II) (see	21, 689	19.0
20. 00	Excess of reasonable cost over customary charges (complete only i	fline 11 exceeds li	ne 18) (see	0	20. 0
01 00	instructions)			21 571	21 0
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			21, 571 0	
23.00	Cost of physicians' services in a teaching hospital (see instruct	i ons)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			15, 197, 324	24.0
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instr	ructions)	2, 809, 947	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines 22	2 and 23] (see	12, 408, 948	27.0
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	
30.00 31.00	Subtotal (sum of lines 27 through 29)			12, 408, 948	
32.00	Primary payer payments Subtotal (line 30 minus line 31)			1, 773 12, 407, 175	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			560, 086 364, 056	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)		356, 840	36. 0
37.00	Subtotal (see instructions)			12, 771, 231	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			-	39.5
39.97	Demonstration payment adjustment amount before sequestration			0	
39.98 39.99	Partial or full credits received from manufacturers for replaced RECOVERY OF ACCELERATED DEPRECIATION	devices (see instruc	ctions)	0	
40.00	Subtotal (see instructions)			12, 771, 231	
40. 01	Sequestration adjustment (see instructions)			0	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.0
	Interim payments			12, 776, 170	
41. 01	Interim payments-PARHM				41.0
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.0 42.0
42.01	Balance due provider/program (see instructions)			-4, 939	
43. 01	Balance due provider/program-PARHM (see instructions)				43.0
44.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44.0
	§115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.0 93.0
	Total (sum of lines 91 and 93)				94.0

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2020 To 06/30/2021		
		Title		Hospi tal	PPS	
		I npati ent	: Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13, 935, 42	6	12, 776, 170	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider			-		
3. 01 3. 02 3. 03	ADJUSTMENTS TO PROVIDER			0 0 0	0 0 0	3. 01 3. 02 3. 03
3.04				0	0	3.04
3.05				0	0	3. 05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM	1		0	0	3.50
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.5
3.51				0	0	3.5
3.53				0	0	3.5
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13, 935, 42	6	12, 776, 170	4.00
	TO BE COMPLETED BY CONTRACTOR	1				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5. Oʻ
5.01				0	0	5.02
5.03				0	0	5.03
	Provider to Program	· · ·				
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.5
5.52				0	0	5.5
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.9
5.00 5.01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 0 6. 0
5. 02	SETTLEMENT TO PROGRAM		107, 65	0	4, 939	6.0
7.02	Total Medicare program liability (see instructions)		13, 827, 77		4, 939	7.0
			10,021,11	Contractor Number	NPR Date (Mo/Day/Yr)	7.0
		0		1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0011 CCN: 15-T011	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part I Date/Time Pre 11/29/2021 7:	epared
		Titl€	e XVIII	Subprovider - IRF	PPS	
		I npati er	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4, 174, 1	0	0	
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02				0	0	
. 03				0	0	
. 04				0	0	
. 05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
~ ~	3. 50-3. 98)					
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)		4, 174, 1	85	0	4.
	TO BE COMPLETED BY CONTRACTOR		1			
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		I			
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	
03				0	0	5.
50	Provider to Program		1	0		
50 51	TENTATI VE TO PROGRAM			0 0	0	
51 52				0		
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER			0	0	6.
02	SETTLEMENT TO PROGRAM		33, 9	87	0	
00	Total Medicare program liability (see instructions)		4, 140, 1		0	7.
				Contractor	NPR Date	
			0	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor		0	1.00	2.00	8

Heal th	Financial Systems MARION GEN	IERAL HOSPI TAL	In Lie	u of Form CMS	6-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0011	Peri od: From 07/01/2020 To 06/30/2021	Date/Time P 11/29/2021	repared:
		Title XVIII	Hospi tal	PPS	
		· · · · · · · · · · · · · · · · · · ·		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL				
1.00	Total hospital discharges as defined in AARA §4102 from		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col				6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructio	ns)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instructior	ns)		32.00

		RAL HOSPITAL		u of Form CMS-2	
CALCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2020	Worksheet E-3 Part III	
		Component CCN: 15-T011	To 06/30/2021	Date/Time Pre 11/29/2021 7:	
		Title XVIII	Subprovider -	PPS	47 ali
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
-	Net Federal PPS Payment (see instructions)			4, 052, 469	1.
	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0375	2.
	Inpatient Rehabilitation LIP Payments (see instructions)			94, 017	3.
	Outlier Payments			44, 293	4.
	Unweighted intern and resident FTE count in the most recen	nt cost reporting period en	ding on or prior	0.00	5.
. 01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE of	count for residents that wer	o displaced by	0.00	5.
	program or hospital closure, that would not be counted with			0.00	5.
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		ment under 42		
	New Teaching program adjustment. (see instructions)			0.00	6.
	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth r	eriod of a "new	0.00	7.
. 00	teaching program" (see instructions)			0.00	/ / .
. 00	Current year's unweighted I&R FTE count for residents with	hin the new program growth p	eriod of a "new	0.00	8.
00	teaching program" (see instructions)	diustment (see instructions)		0.00	
	Intern and resident count for IRF PPS medical education ad	ajustment (see instructions)		0. 00 7. 830137	9. 10.
	Average Daily Census (see instructions) Teaching Adjustment Factor (see instructions)				
	Teaching Adjustment (see instructions)			0. 000000 0	12.
1	Total PPS Payment (see instructions)			4, 190, 779	13.
	Nursing and Allied Health Managed Care payments (see inst	ruction)		4, 190, 779	14.
	Organ acquisition (DO NOT USE THIS LINE)			0	15
	Cost of physicians' services in a teaching hospital (see i	instructions)		0	
	Subtotal (see instructions)			4, 190, 779	
	Primary payer payments			4, 170, 777	18
	Subtotal (line 17 less line 18).			4, 190, 779	
	Deducti bl es			47, 984	
	Subtotal (line 19 minus line 20)			4, 142, 795	
	Coinsurance			2, 597	22.
	Subtotal (line 21 minus line 22)			4, 140, 198	
	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		0	24.
	Adjusted reimbursable bad debts (see instructions)			0	25.
	Allowable bad debts for dual eligible beneficiaries (see i	instructions)		0	26.
	Subtotal (sum of lines 23 and 25)			4, 140, 198	
1	Direct graduate medical education payments (from Wkst. E-	4, line 49)		0	28.
9.00	Other pass through costs (see instructions)			0	29.
D. 00	Outlier payments reconciliation			0	30.
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.
1.50	Pioneer ACO demonstration payment adjustment (see instruct	ti ons)		0	31.
1.99	Demonstration payment adjustment amount before sequestration	i on		0	31.
	Total amount payable to the provider (see instructions)			4, 140, 198	32.
	Sequestration adjustment (see instructions)			0	32.
2. 02	Demonstration payment adjustment amount after sequestration	on		0	32.
3.00	Interim payments			4, 174, 185	
	Tentative settlement (for contractor use only)			0	34.
	Balance due provider/program (line 32 minus lines 32.01, 3			-33, 987	
	Protested amounts (nonallowable cost report items) in access115.2	ordance with CMS Pub. 15-2,	chapter 1,	0	36.
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4			44, 293	50.
1	Outlier reconciliation adjustment amount (see instructions	s)		0	51.
2.00	The rate used to calculate the Time Value of Money			0.00	52.
	Time Value of Money (see instructions)			0	53.

00 I 00 M 00 00 0 00 0 00 0 00 0 00 0 00	ART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER OMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) npatient primary payer payments	Title XIX RVICES FOR TITLES V OR X	From 07/01/2020 To 06/30/2021 Hospi tal Inpati ent 1.00 IX SERVI CES 671, 027	Part VII Date/Time Pre 11/29/2021 7: / Cost Outpati ent 2. 00	
00 I 00 M 00 00 0 00 0 00 0 00 0 00 0 00	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		Inpatient 1.00 IX SERVICES	Cost Outpati ent	
00 I 00 M 00 00 0 00 0 00 0 00 0 00 0 00	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)	RVICES FOR TITLES V OR X	1.00 I X SERVI CES		
00 I 00 M 00 00 0 00 0 00 0 00 0 00 0 00	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)	RVICES FOR TITLES V OR X	IX SERVICES	2.00	
00 I 00 M 00 00 0 00 0 00 0 00 0 00 0 00	COMPUTATION OF NET COST OF COVERED SERVICES npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)	WICES FOR TITLES V OR X			
00 I 00 M 00 C 00 S 00 I 00 C 00 S 00 C R	npatient hospital/SNF/NF services Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		671, 027		
00 M 00 00 00 S 00 I 00 0 00 S 00 S 00 S 00	Medical and other services Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		671,027		1 1 0
00 00 00 5 00 1 00 0 00 5 00 5 00 5 00 5	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)			0	1.0
00 5 00 1 00 00 00 5 00 00	Subtotal (sum of lines 1, 2 and 3)		0	0	3.0
00 I 00 C 00 S R			671, 027	0	
00 0 00 5 00 R			0/1/02/	0	5.0
00 S	Dutpatient primary payer payments			0	6.0
R	Subtotal (line 4 less sum of lines 5 and 6)		671, 027	0	7.0
	OMPUTATION OF LESSER OF COST OR CHARGES				
00 1	easonabl e Charges				
	Routine service charges		524, 067		8. C
	Ancillary service charges		1, 145, 267	0	
	Organ acquisition charges, net of revenue		0		10.0
	ncentive from target amount computation		0		11.0
	Fotal reasonable charges (sum of lines 8 through 11)		1, 669, 334	0	12.0
	USTOMARY CHARGES Amount actually collected from patients liable for payment for	sorvicos on a chargo	0		13.0
	anount actuarty corrected from patients frable for payment for	services on a charge	0	0	13.0
	Amounts that would have been realized from patients liable for	navment for services o	n O	0	14.0
	a charge basis had such payment been made in accordance with 4			Ű	
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.0
5.00	Fotal customary charges (see instructions)		1, 669, 334	0	16. (
7.00 E	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	998, 307	0	17.0
1	ine 4) (see instructions)				
	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	e 0	0	18.0
	16) (see instructions)				1.0
	nterns and Residents (see instructions)		0	0	1
	Cost of physicians' services in a teaching hospital (see instr		0	0	
	Cost of covered services (enter the lesser of line 4 or line 1		671, 027	0	21.0
	ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	compreted for PPS provi	0	0	22. (
	Dutlier payments		0	0	
	Program capital payments		0	0	24.
	Capital exception payments (see instructions)		0		25.
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27.0
3. 00 0	Customary charges (title V or XIX PPS covered services only)		0	0	28.0
9.00	Fitles V or XIX (sum of lines 21 and 27)		671, 027	0	29.0
	OMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		671, 027	0	
	Deducti bl es		0	0	
			0	0	
	Allowable bad debts (see instructions)		0	0	34.
	Jtilization review Subtatal (sum of lines 21, 24 and 25 minus sum of lines 22 and	1 22)	(71 027		35.
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and)THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		671, 027	0	
	Subtotal (line 36 ± line 37)		671, 027	0	
	Direct graduate medical education payments (from Wkst. E-4)		071,027	U	39.
	Fotal amount payable to the provider (sum of lines 38 and 39)		671, 027	0	
	nterim payments		1, 208, 825	0	
	Balance due provider/program (line 40 minus line 41)		-537, 798	0	
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2	0	0	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2020	Worksheet E-3 Part VII	
		Component CCN: 15-T011	To 06/30/2021	Date/Time Pre 11/29/2021 7:	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X		2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		19, 611		1 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		19, 611	0	
00	Inpatient primary payer payments		0	_	5
00	Outpatient primary payer payments		10 (11	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		19, 611	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges		14 100		1.
00 00	Routine service charges Ancillary service charges		14, 190 14, 067	0	
. 00	Organ acquisition charges, net of revenue		14,007	0	10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		28, 257	0	
	CUSTOMARY CHARGES				1
. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	1:
	basi s	-			
. 00	Amounts that would have been realized from patients liable for		n 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
. 00	Total customary charges (see instructions)		28, 257	0	
. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	8, 646	0	1
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds lin	e 0	0	18
. 00	16) (see instructions)	Ty II IIIle 4 exceeds IIII	0	0	
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		19, 611	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1
. 00	Other than outlier payments	· · ·	0	0	22
. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2!
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		19, 611	0	20
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	19, 611	0	
	Deductiblies)	0	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	-	3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	19, 611	0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	3
. 00	Subtotal (line 36 ± line 37)		19, 611	0	38
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		30
. 00	Total amount payable to the provider (sum of lines 38 and 39) $% \left($		19, 611	0	
. 00	Interim payments		29, 211	0	
. 00	Balance due provider/program (line 40 minus line 41)		-9, 600	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0	0	43

I RECT	Financial Systems MARION GENERAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 15-0011	Peri od:	u of Form CMS-2 Worksheet E-4	
IEDI CA	L EDUCATION COSTS			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 7:4	
		Title	XVIII	Hospi tal	PPS	
					1.00	
. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	cost roporti	na pori ods	0.00	1.0
. 00	ending on or before December 31, 1996.			0 1		
. 00 . 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM		1) (see instr	uctions)	0.00 0.00	2.0
. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		§413.79 (m).	(see	0.00	
. 00	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					
. 01					0.00	4.0
. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4.0
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts				0.00	5.0
0.00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0.00	
. 00	Enter the lesser of line 5 or line 6		Primary Care	Other	0.00 Total	7.0
00	Weighted FTF growt for shurising in an ellerathic and establish	-++	1.00	2.00	3.00	0.0
. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.		0.0		0.00	8.0
. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		0.0	0 0.00	0.00	9.0
	Weighted dental and podiatric resident FTE count for the curr			0.00		10.0
0. 01 1. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	irrent year	0.0	0.00 0.00		10.0 11.0
2.00	Total weighted resident FTE count for the prior cost reportin instructions)	ig year (see	0.0			12.0
3. 00	Total weighted resident FTE count for the penultimate cost reyear (see instructions)		0.0			13.0
	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	l by 3).	0. 0 0. 0			14.0 15.0
	Unweighted adjustment for residents in initial years of new programs	rograms	0.0			15. (
	Adjustment for residents displaced by program or hospital clo		0.0			16.
5. 01	Unweighted adjustment for residents displaced by program or h closure	iospi tal	0.0	0 0.00		16.0
	Adjusted rolling average FTE count		0.0			17. (
	Per resident amount Approved amount for resident costs		0.0	0 0.00 0 0	0	18. (19. (
			•		1 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots rec	eived under 42	<u> </u>	20.0
1. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	ictions)			0.00	21. (
	Allowable additional direct GME FTE Resident Count (see instru	,			0.00	
8. 00	Enter the locality adjustment national average per resident a	,	nstructions)		0.00	23.
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0	
. 00			· .	t Managed Care	Total	23.
			A 1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X, line	7, 64			26. (
7.00	3.02, column 2)					27.0
	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		17, 92 0. 42617			27.0
9. 00	Program direct GME amount			0 0	0	29.0
	Percent reduction for MA DGME					29.0
0.00	Reduction for direct GME payments for Medicare Advantage		1	0	0	30.0

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPA	TIENT DIRECT	Provider CCN: 15-0011	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 07/01/2020 To 06/30/2021	Date/Time Pre	arod.
				10 00/30/2021	11/29/2021 7:4	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOS	SITE RATE - TITLE	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
22.00	EDUCATION COSTS) Renal dialysis direct medical education costs	(from Wkot D	Dt l cum of col 20 on	d 22 lines 74	0	22.00
32.00	and 94)	(TTOIN WKSL. B, I	PL. I, SUM OF COL. 20 AN	u 23, Trnes 74	0	32.00
33.00	Renal dialysis and home dialysis total charges	s (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to to		e 32 ÷ line 33)		0.00000	
35.00	Medicare outpatient ESRD charges (see instruct				0	35.00
36.00	Medicare outpatient ESRD direct medical educa				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COS	ST - TITLE XVIII	ONLY			
	Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)				15, 570, 683	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, o				0	38.00
39.00	Cost of physicians' services in a teaching hos	spital (see inst	ructions)		0	39.00
40.00	Primary payer payments (see instructions)				41, 906	
41.00	Total Part A reasonable cost (sum of lines 37	through 39 minu	s line 40)		15, 528, 777	41.00
	Part B Reasonable Cost					
	Reasonable cost (see instructions)				17, 200, 364	
43.00	Primary payer payments (see instructions)				1, 773	43.00
44.00	Total Part B reasonable cost (line 42 minus li				17, 198, 591	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	·			32, 727, 368	
46.00	Ratio of Part A reasonable cost to total reasonable				0.474489	
47.00	Ratio of Part B reasonable cost to total reasonable cost to total reasonable cost setues				0. 525511	47.00
40.00		IN PART A AND PAR	KI B		0	48.00
48.00 49.00	Total program GME payment (line 31) Part A Medicare GME payment (line 46 x 48) (ti		(coo instructions)		0	48.00 49.00
49.00 50.00	Part B Medicare GME payment (line 46 x 48) (ti Part B Medicare GME payment (line 47 x 48) (ti				0	49.00 50.00
50.00	rait b medicale GME payment (The 47 X 48) (th	i ti e Aviii oniy)	(See Thisti uctions)	I	0	50.00

LANC	Financial Systems MARION GENERATION E SHEET (If you are nonproprietary and do not maintain Maintain	Provi der C		eriod:	u of Form CMS-2 Worksheet G	2002-
ınd-t ıly)	ype accounting records, complete the General Fund column		F T	rom 07/01/2020 o 06/30/2021	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	11/29/2021 7: Plant Fund	49 ar
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	1.00	2.00	0.00	1.00	
00	Cash on hand in banks	41, 776, 434		0	0	
00	Temporary investments Notes receivable	45, 632, 086	0	0	0	
00 00	Accounts receivable	59, 287, 193		0	0	
00 00	Other receivable	5, 132, 764		0	0	
00	Allowances for uncollectible notes and accounts receivable	-34, 646, 564		0	0	
00	Inventory	2, 227, 460	0	0	0	7
00	Prepaid expenses	2, 909, 609		0	0	
00	Other current assets	729, 422		0	0	
00	Due from other funds		0	0	0	
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	123, 048, 404	0	0	0	11
00	Land	9, 044, 643	0	0	0	12
. 00	Land improvements	3, 364, 440		0	0	
	Accumulated depreciation	-3, 085, 624		0	0	
00	Buildings	150, 475, 907	0	0	0	15
	Accumulated depreciation	-92, 365, 508	0	0	0	16
	Leasehold improvements	2, 481, 340		0	0	
	Accumulated depreciation	-1, 954, 923		0	0	
	Fixed equipment	3, 509, 530		0	0	
	Accumulated depreciation	-1, 303, 641		0	0	
	Automobiles and trucks Accumulated depreciation	1, 074, 421 -855, 372		0	0	
	Major movable equipment	72, 780, 135		0	0	
	Accumul ated depreciation	-60, 426, 208		0	0	
	Minor equipment depreciable	00, 120, 200	0	0	0	
	Accumulated depreciation	C	0	0	0	
00	HIT designated Assets	C	0	0	0	27
. 00	Accumulated depreciation	C	0	0	0	28
	Minor equipment-nondepreciable	5, 434, 015		0	0	
. 00	Total fixed assets (sum of lines 12-29)	88, 173, 155	0	0	0	30
00	OTHER ASSETS	247 020 502	0	0	0	1 21
	Investments Deposits on Leases	347, 930, 502 0		0	0	
00	Due from owners/officers		0	0	0	
	Other assets	13, 720, 468	, i i i i i i i i i i i i i i i i i i i	0	0	
. 00	Total other assets (sum of lines 31-34)	361, 650, 970		0	0	
	Total assets (sum of lines 11, 30, and 35)	572, 872, 529		0	0	
	CURRENT LI ABI LI TI ES					
. 00	Accounts payable	5, 364, 725	0	0	0	37
	Salaries, wages, and fees payable	10, 768, 010		0	0	
00	Payroll taxes payable	0	0	0	0	
	Notes and loans payable (short term)	0	0	0	0	
. 00 . 00	Deferred income		0	0	0	41
	Accelerated payments Due to other funds		0	0	0	
	Other current liabilities	21, 902, 059		0	0	
	Total current liabilities (sum of lines 37 thru 44)	38, 034, 794			0	
	LONG TERM LI ABI LI TI ES	00,001,771				1
. 00	Mortgage payable	C	0	0	0	46
00	Notes payable	C	0	0	0	47
00	Unsecured Loans	C	0	0	0	48
00	Other long term liabilities	157, 836, 265		0	0	
	Total long term liabilities (sum of lines 46 thru 49)	157, 836, 265		0	0	
00	Total liabilities (sum of lines 45 and 50)	195, 871, 059	0	0	0	51
00	CAPI TAL ACCOUNTS General fund balance	377, 001, 470				52
	Specific purpose fund	377,001,470	0			53
	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant			Ű	0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	377, 001, 470		0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	572, 872, 529			0	60

Heal th	Financial Systems	MARION GENERAL	L HOSPI TAL			In Lie	eu of Form CMS	-2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0011			Worksheet G-	1 epared:
		General	Fund	Speci al	Purpose	e Fund	Endowment Fun	d
		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) (specify) 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)		299, 286, 889 77, 714, 581 377, 001, 470 377, 001, 470 377, 001, 470 0 377, 001, 470		0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 C C C C C C C C C C		1.00 2.00 3.00 4.00 5.00 6.00 7.00 0 1.00 1.00 1.00 2.00 3.00 0 1.00 1.00 1.00 1.00 1.1.00 1.1.00 1.2.00 1.3.00 1.4.00 1.5.00 1.6.00 1.7.00 1.8.00 1.9.00
		Endowment Fund	PI ant	Fund			<u> </u>	
	T	6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		000000000000000000000000000000000000000			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet G-2 Parts I & II Date/Time Pre 11/29/2021 7:4	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		16, 359, 11		16, 359, 115	1.0
2.00	SUBPROVIDER - IPF			0	0	2.0
3.00	SUBPROVIDER - IRF		3, 686, 82		3, 686, 820	3.0
4.00	SUBPROVI DER			0	0	4.0
5.00	Swing bed - SNF			0	0	5.0
6.00	Swing bed - NF			0	0	6.0
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY					7.0 8.0
9.00 9.00	OTHER LONG TERM CARE					9.0
10.00	Total general inpatient care services (sum of lines 1-9)		20, 045, 93	25	20, 045, 935	
10.00	Intensive Care Type Inpatient Hospital Services		20, 045, 7	55	20, 045, 955	10.0
11.00	INTENSIVE CARE UNIT		6, 890, 68	28	6, 890, 688	11.0
12.00	CORONARY CARE UNIT		0, 070, 00		0, 070, 000	12.0
13.00	BURN INTENSIVE CARE UNIT					13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
16.00	Total intensive care type inpatient hospital services (sum of	Lines	6, 890, 68	38	6, 890, 688	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26, 936, 62	23	26, 936, 623	17.0
18.00	Ancillary services		82, 165, 78	36 376, 504, 374	458, 670, 160	18.0
19.00	Outpatient services			0 0	0	19.0
20. 00	RURAL HEALTH CLINIC			0 0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.0
22.00	HOME HEALTH AGENCY					22.0
23.00	AMBULANCE SERVI CES			0 4, 294, 967	4, 294, 967	23.0
24.00	CMHC					24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
26.00	HOSPICE				50 70/ 075	26.0
27.00	PROFESSIONAL FEES		100 100 1	0 58, 706, 975	58, 706, 975	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to WKST.	109, 102, 40	09 439, 506, 316	548, 608, 725	28. 0
	G-3, line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			193, 366, 179		29.0
30.00	ADD (SPECIFY)			0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			0		36.0
37.00	ELIMINATIONS		1, 286, 71	15		37.0
38.00				0		38.0
39.00				0		39.0
40. 00				0		40.0
41.00				0		41.0
42.00	Total deductions (sum of lines 37-41)			1, 286, 715		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2) (transfor		192, 079, 464		43.0

Heal th	Financial Systems	MARION GENERAL I	HOSPI TAI	Inlie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0011	Peri od:	Worksheet G-3	002 10
017112				From 07/01/2020		
				To 06/30/2021		
					11/29/2021 7:2	49 am
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	L column 3 line	28)		548, 608, 725	1.00
2.00	Less contractual allowances and discounts on				353, 312, 460	2.00
3.00	Net patient revenues (line 1 minus line 2)	patrents account	.5		195, 296, 265	3.00
4.00	Less total operating expenses (from Wkst. G-2	2 Part II line 4	3)		192, 079, 464	
5.00	Net income from service to patients (line 3 m				3, 216, 801	5.00
0100	OTHER I NCOME				0/210/001	0.00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				1, 074, 202	7.00
8.00	Revenues from telephone and other miscellaned	ous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gues	sts			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical sup	oplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than pati	ents			0	17.00
18.00	Revenue from sale of medical records and abst				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, ar	nd 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
	OTHER OPERATING INCOME				2, 740, 135	
24.01	PENSION INVESTING				3, 718, 555	
24.02	UNREALI ZED GAI N/LOSS				60, 674, 972	
	CONTRI BUTI ONS				18, 105	
	RECONCILING ITEM				110	
	COVI D-19 PHE Funding				6, 505, 692	
	Total other income (sum of lines 6-24)				74, 731, 771	
	Total (line 5 plus line 25)				77, 948, 572	
	BAD DEBT EXPENSE				233, 991	
28.00	Total other expenses (sum of line 27 and subs				233, 991	
29.00	Net income (or loss) for the period (line 26	minus line 28)			77, 714, 581	29.00

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0011	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Pre	pared:			
			11/29/2021 7:				
	Title XVIII	Hospi tal	PPS				
			1.00				
			1.00				
CAPITAL FEDERAL AMOUNT	PART I - FULLY PROSPECTIVE METHOD						
.00 Capital DRG other than outlier	905, 258	1 1.0					
.01 Model 4 BPCI Capital DRG other than outlier	,00,200						
.00 Capital DRG outlier payments	20, 334						
.01 Model 4 BPCI Capital DRG outlier payments			0				
.00 Total inpatient days divided by number of days in the	e cost reporting period (see inst	tructions)	41.77				
.00 Number of interns & residents (see instructions)							
.00 Indirect medical education percentage (see instruction	Indirect medical education percentage (see instructions)						
.00 Indirect medical education adjustment (multiply line	0	6. (
1.01) (see instructions)							
30) (see instructions)			0.00	8.0			
	5 1 5 5 6 7						
0.00 Allowable disproportionate share percentage (see ins	tructions)		0.00				
1.00 Disproportionate share adjustment (see instructions)	\ \		0				
2.00 Total prospective capital payments (see instructions))		925, 592	12.			
			1.00				
PART II - PAYMENT UNDER REASONABLE COST							
.00 Program inpatient routine capital cost (see instruct)	i ons)		0	1.0			
.00 Program inpatient ancillary capital cost (see instruc	ctions)		0	2.			
.00 Total inpatient program capital cost (line 1 plus li	ne 2)		0	3.			
.00 Capital cost payment factor (see instructions)			0	4.			
.00 Total inpatient program capital cost (line 3 x line	4)		0	5.			
			1.00				
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00				
00 Program inpatient capital costs (see instructions)			0	1.			
00 Program inpatient capital costs (see instructions)	rcumstances (see instructions)		0				
00 Net program inpatient capital costs (line 1 minus lin			0				
00 Applicable exception percentage (see instructions)			0.00				
00 Capital cost for comparison to payments (line 3 x li)	ne 4)		0				
00 Percentage adjustment for extraordinary circumstances			0.00				
00 Adjustment to capital minimum payment level for extra		(line 6)	0	7.			
00 Capital minimum payment level (line 5 plus line 7)	- ·		0	8.			
00 Current year capital payments (from Part I, line 12,	as applicable)		0	9.			
).00 Current year comparison of capital minimum payment le	evel to capital payments (line 8	less line 9)	0	10.			
.00 Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14)	el over capital payment (from pri	or year	0	11.			
2.00 Net comparison of capital minimum payment level to ca	apital payments (line 10 plus lir	ne 11)	0	12.			
3.00 Current year exception payment (if line 12 is positiv			0	13.			
1.00 Carryover of accumulated capital minimum payment leve	el over capital payment for the f	following period	0	14.			
(if line 12 is negative, enter the amount on this lin							
			0	15.			
5.00 Current year allowable operating and capital payment			-				
5.00 Current year allowable operating and capital payment 5.00 Current year operating and capital costs (see instruct 7.00 Current year exception offset amount (see instruction	ctions)		0	16			