Heal th Financi	al Systems	MARION GENERAL	HOSPI TAL	In Lieu	J of Form CMS-2552-10
	s required by law (42 USC 1395g;				
payments made	since the beginning of the cost	reporting period being	g deemed overpayments (42 USC 1395g).	OMB NO. 0938-0050
					EXPI RES 03-31-2022
	HOSPITAL HEALTH CARE COMPLEX COS	T REPORT CERTIFICATION	Provider CCN: 15-0011	Period: From 07/01/2021	Worksheet S Parts I-III
AND SETTLEMEN	I SUMMARY			To 06/30/2022	Date/Time Prepared:
					11/30/2022 9:15 am
	REPORT STATUS				
Provi der	1. [X] Electronically prepared			Date: 11/30/2	022 Time: 9:15 am
use only	2. [] Manually prepared cost				
	3.[0]If this is an amended r 4.[F]Medicare Utilization. E	report enter the number	of times the provider	resubmitted this c	cost report
Contractor		Date Received:		NPR Date:	
use only	(1) Ås Submitted 7.	Contractor No.	11.	Contractor's Vendo	or Code: 4
use only	(2) Settled without Audit 8.	[N] Initial Report fo	or this Provider CCN12.	[0] f line 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit 9.	[N] Final Report for	this Provider CCN	number of tim	nes reopened = 0-9.
	(4) Reopened				
	(5) Amended				
PART LL - CER	TIFICATION BY A CHIEF FINANCIAL	OFFLCER OR ADMINISTRAT	OR OR PROVIDER(S)		
	TION OR FALSIFICATION OF ANY INF			PUNI SHABLE BY CRI	MINAL, CIVIL AND
	E ACTION, FINE AND/OR IMPRISONME				
PROVIDED OR P	ROCURED THROUGH THE PAYMENT DIRE	CTLY OR INDIRECTLY OF	A KICKBACK OR WERE OTHE	RWISE ILLEGAL, CRI	MINAL, CIVIL AND
ADMI NI STRATI V	E ACTION, FINES AND/OR IMPRISONM	ENT MAY RESULT.			
CERTI	FICATION BY CHIEF FINANCIAL OFFI	CER OR ADMINISTRATOR O	f PROVIDER(S)		
I HFR	EBY CERTIFY that I have read the	above certification s	tatement and that I hav	e examined the acc	companyi ng
	ronically filed or manually subm				1 5 5
	ment of Revenue and Expenses pre				
begi n	ning 07/01/2021 and ending 06/30	/2022 and to the best	of my knowledge and bel	ief, this report a	and statement
	rue, correct, complete and prepa				
	cable instructions, except as no				
	ding the provision of health car		he services identified	in this cost repor	t were
provi	ded in compliance with such laws	and regulations.			

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Ton	y Roberts	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Tony Roberts			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	225, 933	-71, 071	0	-341, 301	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	67, 631	0		-33, 566	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	293, 564	-71, 071	0	-374, 867	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 AL AND HOSPITAL HEALTH CARE COMPLEX	MARION GENERA				Period: From 07/01/	2021	of For Workshe Part I	eet S-2	
						To 06/30/	2022	Date/Ti 11/30/2		
	1.00	2.00		3.00		2	1.00			
	<u>Hospital and Hospital Health Care Co</u> Street: 441 WABASH AVENUE	PO Box:								1 1 0
	City: MARION	State: IN	Zip Code	46952	- Count	y: GRANT				1.0 2.0
00		Component Name	CCN	CBSA	Provi der	Date	Payme	nt Syst	em (P,	2.0
		•	Number	Number	- Туре	Certified		0, or		
							V	XVIII		
	Hospital and Hospital-Based Componer	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	Р	0	3.0
	Subprovi der – IPF			,,,,,,,						4.0
. 00	Subprovider - IRF	MARION GENERAL HOSPITAL	15T011	99915	5	07/01/2005	Ν	P	0	5.0
~~		REHAB								
	Subprovider - (Other) Swing Beds - SNF									6.0
	Swing Beds - NF									8.0
	Hospital-Based SNF									9.0
	Hospital-Based NF									10.0
	Hospital-Based OLTC									11.0
	Hospital-Based HHA									12.0
	Separately Certified ASC									13.0
	Hospital-Based Hospice									14.0
	Hospital -Based Health Clinic - RHC									15.0
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16.0 17.0
	Renal Dialysis									18.
	Other									19.0
			·			From:		То		
						1.00	204	2.0		0.0
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					07/01/20)21	06/30/	2022	20.0
1.00	Type of control (see thist detrolis)					2				21.0
					1.00	2.00		3. (00	1
	Inpatient PPS Information									
2.00	Does this facility qualify and is it				Y	N				22.0
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			K						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
2. 01	Did this hospital receive interim un				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 reporting period occurring on or aft			COST						
> 02	is this a newly merged hospital that			P	Ν	N				22.0
. 02	payments to be determined at cost re									22.
	Enter in column 1, "Y" for yes or "N			,						
	cost reporting period prior to Octob	er 1. Enter in column 2,	"Y" for	yes						
	or "N" for no, for the portion of th	e cost reporting period	on or aft	er						
0.02	October 1. Did this beenitel reasive a geograph	i a raal aadifi aati an fra	. urban ta		N	N		N		22
2.03	Did this hospital receive a geograph rural as a result of the OMB standar				Ν	N		N		22.0
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for	no for the portion of th	ne cost							
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 12 CED 11	2. TOS) ? Enter Th Corumn	3, Y IC							
	counted in accordance with 42 CFR 41		urbon to	,	Ν	N		N		22.
	yes or "N" for no.	ic reclassification from								
	yes or "N" for no. Did this hospital receive a geograph			eas						
. 04	yes or "N" for no.	delineations for statis	stical are							
. 04	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	delineations for statis column 1, "Y" for yes o g period prior to Octobe	stical are ~ "N" for er 1. Ente	no						
2. 04	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	delineations for statis column 1, "Y" for yes on g period prior to Octobe no for the portion of th	stical are ~ "N" for er 1. Ente ne cost	no						
2. 04	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	delineations for statis column 1, "Y" for yes of g period prior to Octobe no for the portion of th er October 1. (see inst	stical are - "N" for er 1. Ente ne cost ructions)	no er						
2. 04	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	delineations for statis column 1, "Y" for yes of g period prior to Octobe no for the portion of th er October 1. (see inst 100 but not more than 40	stical are - "N" for er 1. Ente ne cost ructions) 29 beds (a	no er						
2. 04	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	delineations for statis column 1, "Y" for yes of g period prior to Octobe no for the portion of th er October 1. (see inst 100 but not more than 40	stical are - "N" for er 1. Ente ne cost ructions) 29 beds (a	no er						
2. 04	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.	delineations for statis 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 40 2.105)? Enter in column	stical are r "N" for er 1. Ente ne cost ructions) 29 beds (a n 3, "Y" f	no er as for		3 N				23
2. 04	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	delineations for statis 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 40 2.105)? Enter in column dicaid days on lines 24	stical are r "N" for er 1. Ente ne cost ructions) 29 beds (a n 3, "Y" f and/or 25	no er is for		3 N				23. (
2. 04 8. 00	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	delineations for statis 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 44 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	stical are r "N" for er 1. Entene cost ructions) 29 beds (a n 3, "Y" f and/or 25 us days, c in this c	no er es for for or 3		3 N				23.

	GENERAL HO				In Lieu			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA F	Provider CC	N: 15-0011	Period: From 07/0	1/2021 F	lorkshe Part I		
						1/30/2	022 9:	pared: <u>15 am</u>
	In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medicai HMO days		her i cai d	
	paid days	eligible unpaid	Medicaid paid days	Medicaid eligible	5	d	ays	
		days	paru uays	unpai d				
24.00 If this provider is an IPPS hospital, enter the	1.00 716	2.00 156	3.00	4.00	5.00 3,8		. 00 0	24.00
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	25			0		32	0	25.00
25.00 f this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	25		0					25.00
				Urban/R	ural S D	<u>ate of</u> 2.0		
26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the be	ginning of		2			26.00
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status r "2" for r ication in	rural. If a column 2.	ppl i cabl e,		2			27.00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	^r periods S	CH status i	n	1			35.00
				Begi ni		Endi 1 2. 0		
36.00 Enter applicable beginning and ending dates of SCH st		script line	36 for num			06/30/		36.00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	es. r the numbe	er of perio	ds MDH stat	us	0			37.00
37.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.01
 instructions) 38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 								38.00
				Y/		<u> </u>		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet the		diustment	for low vol				-	20.00
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no (see instructions)	the mileage	· (iii)? En e requireme	ter in colu nts in	mn		N		39.00
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	the mileage ii)? Enter n adjustmen per 1. Ente	(iii)? En e requireme in column nt? Enter " er "Y" for	ter in colu nts in 2 "Y" for y Y" for yes	mn res or N		N		40.00
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction	the mileage ii)? Enter n adjustmen per 1. Ente	(iii)? En e requireme in column nt? Enter " er "Y" for	ter in colu nts in 2 "Y" for y Y" for yes	mn res or N	V	N	XI X 2.00	
<pre>or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital</pre>	the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst	(iii)? En e requireme in column er "Y" for ructions)	ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	mn es or N for	V 1.00	N	XI X 3. 00	
 or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymer 	the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst	(iii)? En e requireme in column er "Y" for ructions)	ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	mn es or N for	V 1.00	N		
 or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoben no in column 2, for discharges on or after October 1. 45.00 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412. 320? (see instructions) 46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412. 348(f)? If yes, complete Wkst 	the mileage i)? Enter n adjustmen per 1. Ente (see inst nt for disp eption for	<pre>(iii)? En e requireme in column at? Enter " er "Y" for aructions) proportiona extraordin</pre>	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	mn or M for accordance tances	V 1.00	N XVIII 2.00	3.00	40.00
 or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment 	the mileage ii)? Enter n adjustmen per 1. Ente . (see inst nt for disp eption for t. L, Pt. I capital? E	requireme in column of? Enter " er "Y" for rructions) proportiona extraordin II and Wks	ter in colu nts in 2 "Y" for y Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N	mn es or N for A accordance tances I through	V 1.00	N XVIII 2.00 N	3.00 N	40.00
 or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of 88.00 Is the facility electing full federal capital payment Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic 	the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs)	(iii)? En e requireme in column at? Enter " er "Y" for eructions) oroportiona extraordin II and Wks nter "Y for Y" for yes ME program of 1 is "Y", the prior	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	mn es for for accordance tances l through " for no. " no. " for yes o hospital ultimate	V 1.00 N N N N N N N N	N XVIII 2.00 N N N	3.00 N N	40. 00 45. 00 46. 00 47. 00
 or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. 45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME prior 	the mileage ii)? Enter n adjustmen per 1. Enter . (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet	<pre>(iii)? En e requireme in column at? Enter " er "Y" for ructions) oroportiona extraordin II and Wks Enter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee</pre>	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	mn es or for for accordance tances I through "for no. no. "for yes o hospital ultimate reduction? approved If column ? Enter "N	V 1.00 N N N N N 1	N XVIII 2.00 N N N	3.00 N N	40. 00 45. 00 46. 00 47. 00 48. 00
 or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. 45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N" 	the mileage i)? Enter n adjustmen per 1. Enter (see inst (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column caple CRs lumn 2. period duri r yes or "N th of this y", complet J, if appli pursement f	(iii)? En e requireme in column at? Enter " er "Y" for cructions) proportiona extraordin II and Wks enter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which re " for no i cost repor e Workshee cable. for physici	ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	mn es or for for accordance tances l through " for no. no. " for yes of hospital ultimate reduction? approved lf column ? Enter "Y olumn 2 is	V 1.00 N N N N N 1	N XVIII 2.00 N N N	3.00 N N	40.00 45.00 46.00 47.00 48.00 56.00

Health Financial Systems MARION	GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO	CN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/30/2022 9:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
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. CR) NAHI	see If column 1	N			60.00
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) (1.01 Enter the suprage purpher of unusidated primery core 				0.00	0.00	61.00
61.01 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 instructions)						61.01
61.02 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 current cost reporting period. (see instructions). 						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
 61.04 minus line 61.03). (see instructions) 61.06 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 Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program 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				0.00	0. 00	61.10
 FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting po	eriod for which	0.00	62.00
62.01 Énter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	n Teachi gram. (s	see instructio		to your hospital	0.00	62. 01
 63.00 Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, completing 	ettings	during this o			N	63.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMP		ATA Providei		Period:	Worksheet S-2	2552-1 2
					rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre 11/30/2022 9:	
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTES	FTEs in	1/ (col. 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
				1.00	2.00	3.00	1
	Section 5504 of the ACA Base Yea	r FTE Residents in M	lonprovider Setting				
. 00	period that begins on or after J Enter in column 1, if line 63 is			its 0.0	0 0.00	0. 000000	64 0
. 00	in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the rat		0.00	0.00000	04.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		·····		FTEs	FTEs in	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
				Si te			
		1.00	2.00	3.00	4.00	5.00	
. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		n Nonprovi der Sett	0.00 Unweighted FTEs Nonprovider Site 1.00 tingsEffective	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00	-
. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. The resident 3 the ratio of	0.0	0 0.00	0. 000000) 66.C
	(column 1 divided by (column 1 +	Column 2)). (see in Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTEs	FTEs in	3/ (col . 3 +	
				Nonprovi der	Hospi tal	col. 4))	
				Si te			
		1.00	2.00	3.00	4.00	5.00	
. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.0	0 0.00	0. 000000	

Heal th	Financial Systems MARION GENERAL HOSPITAL	١r	Lieu	of Form	n CMS-2	2552-10
HOSPI T	F	eriod: rom 07/01/ o 06/30/	2021 2022	Workshe Part I Date/Ti 11/30/2	me Pre	pared:
				2.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	provi der?	N 11.00	2.00	0.00	70.00
	Enter "Y" for yes or "N" for no.		N		0	
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "V" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	no. (see chi ng no.			0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Y			75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in	the most	N	N	0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions)	or "N" for e with 42 4				
				1.0	0	_
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	g period? E	Inter	N N		80.00 81.00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio		no.	N		85.00 86.00
	<pre>\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>			Ν		87.00
		V 1.00		XI 2 2. 0		
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. 0 N	0	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 Y		0. 0 Y	0	97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column ?	N		N		98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N		N		98.04
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y		Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.06
105 00	Rural Providers Does this hospital qualify as a CAH?	N				105.00
	If this facility qualify as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an	N				107.00
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems MARION GENERAL	HOSPI TAL		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: com 07/01/2021 o 06/30/2022	Worksheet S- Part I Date/Time Pr 11/30/2022 9	- epared:
			V 1.00	XI X 2.00	_
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	N	2.00	108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	100.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
	Domonstrati	on project (84	104	1.00 N	110.00
Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. I	f yes,	N	
			1.00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting Dumn 1 is Y, ticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	period? s "Y", enter ne	N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes rs) based on				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	Y			116.00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence pol		1			118.00
if the policy is claim-made. Enter 2 if the policy is occurr	rence.	Premiums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 1,365,515	2.00	3.00	0118.01
		· · ·			
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			1.00 N	2.00	118.02
119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Extension and applicable amendment for the former and	n column 1, "N ualifies for 1	for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Ν		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N'	'forno.lf	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, er	-				126.00
in column 1 and termination date, if applicable, in column 2	2.				127.00
127.00 f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				
128.00 f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				128.00 129.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation udte in			129.00

Ith Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE	MARION GE X IDENTIFICATION DATA	Provider CC	N: 15-0011	From C	: 7/01/2021 6/30/2022		reparec
						11/30/2022	9: 15 all
).00 If this is a Medicare certified pa	ancroas transplant con	tor optor the cor	ti fi cati or		1.00	2.00	130.0
date in column 1 and termination of			tincatio	'			130.0
1.00 If this is a Medicare certified in date in column 1 and termination (erti fi cati	on			131. (
2.00 If this is a Medicare certified is			ication da	ate			132.0
in column 1 and termination date,	if applicable, in col	umn 2.					100
3. OORemoved and reserved 4. OOIf this is an organ procurement of and termination date, if applicable applicable	5	er the OPO number	in column	1			133. 134.
All Providers 0.00 Are there any related organization chapter 10? Enter "Y" for yes or '	'N" for no in column 1	. If yes, and home	office co		N		140.
are claimed, enter in column 2 the 1.00	e nome office chain hu	2.00	tions)		3.00		
If this facility is part of a chai		on lines 141 thro	ugh 143 tl	he name a		of the home	
office and enter the home office of .00Name:	Contractor name and co		Contra	actor's Nu	mber:		141.
2.00Street:	PO Box:						142.
3. 00 Ci ty:	State:		Zip Co	ode:			143.
						1.00	_
1.00 Are provider based physicians' cos	sts included in Worksh	eet A?				Y	144.
					1.00	2.00	-
5.00 If costs for renal services are cl inpatient services only? Enter "Y' no, does the dialysis facility inc period? Enter "Y" for yes or "N"	' for yes or "N" for n clude Medicare utiliza	o in column 1. If	column 1 i				145.
		oviously filed cos	t report?		••		146.
b. 00 Has the cost allocation methodol of Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/of)	n column 1. (See CMS P			lf	N		
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	n column 1. (See CMS P dd/yyyy) in column 2.	ub. 15-2, chapter	40, <u>\$</u> 4020)	If	N	1.00	
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00Was there a change in the statisti	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y"	ub. 15-2, chapter	40, §4020) no.	lf	N	N	147.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" fallocation? Enter "Y	ub. 15-2, chapter for yes or "N" for " for yes or "N" f d? Enter "Y" for y	40, \$4020) no. or no. es or "N"	for no.		N N N	147. 148. 149.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00Was there a change in the statisti 3.00Was there a change in the order of	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" fallocation? Enter "Y	ub. 15-2, chapter for yes or "N" for " for yes or "N" f d? Enter "Y" for y Part A	40, \$4020) no. or no. es or "N" Part	for no.	ītle V	N N Title XIX	147. 148. 149.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00Was there a change in the statisti 3.00Was there a change in the order of	foclumn 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" fallocation? Enter "Y ed cost finding metho	ub. 15-2, chapter for yes or "N" for " for yes or "N" f d? Enter "Y" for y Part A 1.00	40, \$4020) no. or no. es or "N" Part 2.00	for no.	-itle V 3.00	N N Title XIX 4.00	147. 148. 149.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00Was there a change in the statisti 8.00Was there a change in the order of 0.00Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A	no. or no. es or "N" Part 2.00 m the app	for no. B 1	itle V 3.00 of the low 42 CFR §41	N N Title XIX 4.00 ver of costs 3.13)	147. 148. 149.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " 5.00 Hospital	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N	no. or no. es or "N" Part 2.00 m the app and Part N	for no. B 1	Title V 3.00 Df the low 42 CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	147. 148. 149. 155.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00 Was there a change in the statisti 3.00 Was there a change in the order of 0.00 Was there a change to the simplifi 0.00 Hospital 0.00 Subprovider - IPF 7.00 Subprovider - IRF	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A	no. or no. es or "N" Part 2.00 m the app	for no. B 1	itle V 3.00 of the low 42 CFR §41	N N Title XIX 4.00 ver of costs 3.13)	147. 148. 149. 155. 155. 156. 157.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi Does this facility contain a provior or charges? Enter "Y" for yes or 5.00 Hospital .00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N N N	no. or no. es or "N" Part 2.00 m the app and Part N N N	for no. B 1	Title V 3.00 of the low 42 CFR §41 N N N	N N Title XIX 4.00 rer of costs 3.13) N N N	147. 148. 149. 155. 155. 156. 157. 158.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 2.00 Was there a change in the statisti 8.00 Was there a change in the order of 0.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or 5.00 Hospital 0.00 Subprovider - IPF 2.00 Subprovider - IRF 3.00 SUBPROVIDER 0.00 SNF	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N	no. or no. es or "N" Part 1 2.00 m the appi and Part N	for no. B 1	Title V 3.00 Df the low 42 CFR §41 N N	N N Title XIX 4.00 ver of costs 3.13) N N	147. 148. 149. 155. 156. 156. 157. 158. 159.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 2.00 Was there a change in the statisti 8.00 Was there a change in the order of 0.00 Was there a change to the simplifi Does this facility contain a proviour or charges? Enter "Y" for yes or " 5.00 Hospital 0.00 Subprovider - IPF 2.00 Subprovider - IRF 8.00 SUBPROVIDER 0.00 SNF 0.00 HOME HEALTH AGENCY	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo	ub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N N N	no. or no. es or "N" Part 2.00 m the app and Part N N N	for no. B 1	Title V 3.00 of the low 42 CFR §41 N N N N	N N Title XIX 4.00 Ver of costs 3.13) N N N	147. 148. 149. 155. 156. 157. 158. 157. 158. 159. 160.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi 0.00 Hospital 0.00 Subprovider - IPF 7.00 Subprovider - IPF 9.00 SUBPROVIDER 9.00 SNF 9.00 HOME HEALTH AGENCY	column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo	ub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N N N	40, \$4020) no. or no. es or "N" Part 2.00 m the appl and Part N N N N N	for no. B 1	Title V 3.00 of the low 42 CFR §41 N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 5.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus	n column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo 'N" for no for each co	ub. 15-2, chapter for yes or "N" for " for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N N	no. or no. es or "N" Part 2.00 m the appi and Part N N N N N N	for no. B 1 Iication B. (See	Title V 3.00 of the low 42 CFR §41 N N N N N N N N	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi Does this facility contain a provior or charges? Enter "Y" for yes or " 5.00 Hospital 0.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica	n column 1. (See CMS P dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho der that qualifies fo 'N" for no for each co	ub. 15-2, chapter for yes or "N" for " for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N N	no. or no. es or "N" Part 2.00 m the appi and Part N N N N N N	for no. B 1 Iication B. (See	Title V 3.00 of the low 42 CFR §41 N N N N N N N N	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi 0.00 Was there a change to the simplifi 0.00 Was there a change to the simplifi 0.00 Hospital 0.00 Subprovider - IPF 2.00 Subprovider - IRF 3.00 SUBPROVIDER 0.00 SNF 0.00 HOME HEALTH AGENCY 0.00 CMHC	ampus hospital that ha: Name	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N N N N Sone or more camp County	no. or no. es or "N" Part 1 2.00 m the app and Part N N N N N N N N N State	for no. B 1 B 2 B (See fferent (Zip Code	Title V 3.00 of the low 42 CFR §41 N N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N T.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d .00 Was there a change in the statisti .00 Was there a change in the order of .00 Was there a change to the simplifi .00 Subprovider - IPF .00 Subprovider - IPF .00 SUBPROVIDER .00 SNF .00 HOME HEALTH AGENCY .00 CMHC .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that har	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N N N N N S one or more camp	no. or no. es or "N" Part 1 2.00 m the appl and Part N N N N N N N	for no. B 1 B. (See fferent (Title V 3.00 of the low 42 CFR 541 N N N N N N N SBSAs?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N T.00 FTE/Campus 5.00	147 148 149 155 156 157 158 159 160 161
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi Does this facility contain a provior or charges? Enter "Y" for yes or " 5.00 Hospital 0.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica	ampus hospital that ha: Name	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N N N N Sone or more camp County	no. or no. es or "N" Part 1 2.00 m the app and Part N N N N N N N N N State	for no. B 1 B 2 B (See fferent (Zip Code	Title V 3.00 of the low 42 CFR §41 N N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N T.00 FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 0.00 Was there a change in the statisti 0.00 Was there a change in the order of 0.00 Was there a change to the simplifi 0.00 Subprovider - IPF 0.00 Subprovider - IPF 0.00 Subprovider - IRF 0.00 SUBPROVI DER 0.00 SUBPROVI DER 0.00 SUBPROVI DER 0.00 HE HEALTH AGENCY 0.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha: Name	tub. 15-2, chapter for yes or "N" for "for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro mponent for Part A N N N N Sone or more camp County	no. or no. es or "N" Part 1 2.00 m the app and Part N N N N N N N N N State	for no. B 1 B 2 B (See fferent (Zip Code	Title V 3.00 of the low 42 CFR §41 N N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 0.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 3.00 SUBPROVI DER 9.00 SUBPROVI DER 9.00 SNF 0.00 HME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that hat hat hat hat hat hat hat hat ha	tub. 15-2, chapter for yes or "N" for " for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N S one or more camp County 1.00	no. or no. es or "N" Part 2.00 m the appi and Part N N N N N N uses in di State 2.00	for no. B 1 B. (See B. (See fferent (Zip Code 3.00	Title V 3.00 of the low 42 CFR §41 N N N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N T.00 FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi 0.00 Subprovider - 1PF 2.00 Subprovider - 1PF 2.00 Subprovider - 1RF 3.00 SUBPROVI DER 0.00 SUBPROVI DER 0.00 SNF 0.00 HE HEALTH AGENCY 0.00 CMHC Multicampus 5.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user	ampus hospital that ha: Name 0 1) incentive in the Am o under §1886(n)? Entr	tub. 15-2, chapter for yes or "N" for "for yes or "N" for yes or "N" for yeart A 1.00 or an exemption from mponent for Part A N N N N S one or more camp County 1.00 teri can Recovery an er "Y" for yes or	40, \$\$4020\$ no. or no. es or "N" Part 1 2.00 m the apply and Part N	for no. B 1 I i cati on 0 B. (See - fferent (Zip Code 3.00 tment Act	Title V 3.00 of the low 42 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166. 00 166.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi Does this facility contain a provior or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 3.00 SUBPROVI DER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 5.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 3.00 If this provider is a CAH (line 10	in column 1. (See CMS Pridd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "Y" ed cost finding method ider that qualifies fo Name 0 <	tub. 15-2, chapter for yes or "N" for "for yes or "N" for d? Enter "Y" for y Part A 1.00 or an exemption from mponent for Part A N N N N N S one or more camp County 1.00 to yes or taningful user (lin	40, \$\$4020\$ no. or no. es or "N" Part 1 2.00 m the apply and Part N	for no. B 1 I i cati on 0 B. (See - fferent (Zip Code 3.00 tment Act	Title V 3.00 of the low 42 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166. 00 166.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 2.00 Was there a change to the simplifi Does this facility contain a provior or charges? Enter "Y" for yes or " 5.00 Hospital 5.00 Subprovider - IPF 2.00 Subprovider - IRF 3.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 IS this hospital part of a Multica Enter "Y" for yes or "N" for no. 5.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user	ampus hospital that ha Name 0 1) incentive in the Am ot a \$1886(n)? Enter 0 0 1) incentive in the Am ot a sets (see instru- tot a meaningful user,	tub. 15-2, chapter for yes or "N" for " for yes or "N" f d? Enter "Y" for y Part A 1.00 or an exemption frc omponent for Part A N N N N S one or more camp <u>County</u> 1.00 herican Recovery an er "Y" for yes or aningful user (lin ctions) does this provide	no. or no. es or "N" Part 2.00 m the appi and Part N N N N N N N N N N N N N N N N N N N	for no. B 1 li cati on B. (See - B. (See	Title V 3.00 of the low 42 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.

Health Financial Systems	MARI ON GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	
				Part I Date/Time Pre	narod
			0 00/30/2022	11/30/2022 9:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and ending da	ate for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans re	ported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum	n 1. lf column 1 is yes, e	enter the number of sectio	n		
1876 Medicare days in column 2. (se	e instructions)				

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Pro 11/30/2022 9	epared
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	fam al L NO m		1.00	2.00	
	mm/dd/yyyy format.		esponses. Em	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					-
I. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
1.00	reporting period? If yes, enter the date of the change in c					
			Y/N	Date	V/I	
		0.1.6	1.00	2.00	3.00	
2.00	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 3, "V" for	N			2.0
3. 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	
			1.00	2.00	3.00	
4. 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.	or Compiled,	Y	A		4.0
5.00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec		1	Y/N	Legal Oper.	
				1.00	2.00	
5.00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If yos in	c the provide	er N		6.0
5. 00	is the legal operator of the program?	2. TI yes, T	s the provide			0.0
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	ne N		7. (8. (
9.00	Are costs claimed for Interns and Residents in an approved		cal educatior	ר N		9. (
10.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		the current	Ν		10. (
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11. (
					1.00	+
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I	fyes, see ir	nstructions.	Ν	14.
5.00	Did total beds available change from the prior cost reporti				Y	15.
	_		t A Dato		t B Dato	-
	-	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	Ν		N		16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	09/28/2022	Y	09/28/2022	17.
8.00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

	Financial Systems MARION GENER/ AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0011	Peri od:	u of Form CM Worksheet S	
				From 07/01/2021 To 06/30/2022	Part II Date/Time P 11/30/2022	
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
01 00	We discuss the second sec	1.00	2.00	3.00	4.00	01.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS	HOSPI TALS)			_
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense			ring the cost		23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost r	eporting period?		24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rting period	?lfyes, see		25.00
26. 00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during th	he cost report	ing period?	lfyes, see		26.00
27.00	instructions. Has the provider's capitalization policy changed during the		51	,		27.00
00	copy. Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit en	ntered into du	ring the cos	t reporting		28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)		29.00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mate		debt?lf ye	s, see		30.00
31.00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt?lfye	s, see		31.00
	i nstructi ons. Purchased Servi ces					-
32.00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		ed through c	ontractual		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	,	33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an an	rrangement wit	h provider-b	ased physi ci ans?		34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	isting agreeme	ents with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
	llama Offica Casta			1.00	2.00	
36 00	Home Office Costs Were home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office	?		37.00
38.00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider 1 from onter in column 2 the fiscal year and			f		38.00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			s,		39.00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00
	instructions.					
	Cast Depart Dreparer Contact Information	1.	00	2.	00	
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TINA		SEVERS		41.00
41.00		1				
	respectively.					12 00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., 317-713-7946	LLC	TSEVERS@BLUEAN		42.00

Heal th	Financial Systems MARION GE	NER	AL HOSPITAL		In Lieu	of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011			Worksheet S-2	
				To		Part II Date/Time Pre 11/30/2022 9:	pared: <u>15 am</u>
			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	3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cos	st					43.00
	report preparer in columns 1 and 2, respectively.						

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0011	Period: From 07/01/2021 To 06/30/2022	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre	8
						11/30/2022 9: I/P Days / 0/P Visits /	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Trips Title V	
		Line Number		Avai I abl e	1.00	5.00	L
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1.00	2.00	3.00	4.00 85 0.00	5.00	1.00
2. 00	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)	50.00		52, 1			2.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider						3.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		89	32, 48	85 0.00	0	7.00
8.00	INTENSI VE CARE UNI T	31.00	19	6, 93	35 0.00	0	8.00
9.00 10.00 11.00 12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						9.00 10.00 11.00 12.00
13.00	NURSERY	43.00				0	
14.00	Total (see instructions)		108	39, 42	20 0.00	0	
15.00	CAH visits		_			0	
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	40.00 41.00	0 18		0	0	
18.00	SUBPROVI DER	41.00	0		0	0	
9.00	SKILLED NURSING FACILITY				-	-	19.0
20.00	NURSING FACILITY						20.0
21.00 22.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.0
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.0
4.00	HOSPI CE						24.0
	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC	89.00				0	26.0
6.25 7.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	126			0	26.2
8.00	Observation Bed Days		120			0	
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF		0		0		31.0
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U		32.0
	outpatient days (see instructions)						02.0
33.00	LTCH non-covered days						33.0
33.01	LTCH site neutral days and discharges						33.0

HOSPI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	MARION GENERAL AL DATA	Provi der CC	N: 15-0011	Peri od:	u of Form CMS-: Worksheet S-3	
					From 07/01/2021 To 06/30/2022	Part I	epared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6,00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10, 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 425	716	12, 58		10.00	1.00
	8 exclude Swing Bed, Observation Bed and		_				
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	4, 873	4, 015				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	248	332				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4, 425	716	12, 58	6	-	7.00
8.00	INTENSIVE CARE UNIT	783	0	4, 19	7		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	1, 50	9		13.00
14.00	Total (see instructions)	5, 208	716	18, 29	2 0.00	697.91	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF	0	0		0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	1, 479	25	2, 71	9 0.00	14.99	17.00
18.00	SUBPROVIDER		0		0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			7	2		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	712.90	27.00
28.00	Observation Bed Days		1, 088	4, 37			28.00
29.00	Ambul ance Trips	1, 256	,				29.00
30.00	Employee discount days (see instruction)	.,		9	2		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	o		0		32.00
32.01	Total ancillary labor & delivery room				0		32.01
52.01	outpatient days (see instructions)				-		
33.00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	Ö			1		33.01

Full Time Equivalents Nonpaid Workers 11.00	Title V	Dis Title XVII	scharges I Title XIX	11/30/2022 9: Total All	
Nonpaid Workers		Title XVII	I Title XIX	Total ALL	
	10.00				
11.00		-		Patients	
	12.00	13.00	14.00	15.00	
0.00 0.00 0.00 0.00 0.00		0 1, 2 0 1	190 945 0 25 46 145 0 0 52 3	4, 026 4, 026 0 313 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 15.00 14.00 21.00 22.00 23.00 24.00 24.00 24.00 25.00 24.00 25.00 26.00 26.25 27.00 28.00 29.00 30.00 21.00 26.00 26.00 26.00 27.00 26.00 26.00 26.00 27.00 26.00 27.00 27.00 27.00 21.
	0.00 0.00 0.00	0.00 0.00 0.00	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		0.00 0.00 0.00 0.00 0.00 0.00 0.00 0 0.00 0 0 0 0 0 0 0 0 0 0 0 0

SPLL	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part II Date/Time Pre 11/30/2022 9:	par
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200.00	60, 848, 323	22, 977, 748	83, 826, 07	1 1, 832, 430. 00	45.75	1
	instructions)							
0	Non-physician anesthetist Part A		0	0		0 0.00	0.00	2
0	Non-physician anesthetist Part		0	0		0.00	0.00	
	В							
0	Physician-Part A - Administrative		653, 693	0	653, 69	3 2, 868. 81	227.86	
1	Physicians - Part A - Teaching		0	0		0.00	0.00	
0	Physician and Non		6, 054, 441					
_	Physician-Part B		_					
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0		0 0.00	0.00	
0	Interns & residents (in an	21.00	0	о		0.00	0.00	
	approved program)		-	-				
)1	Contracted interns and residents (in an approved		0	0		0 0.00	0.00	7
	programs)							
00	Home office and/or related		0	0		0 0.00	0.00	6
	organization personnel	44.00	0			0 0 00	0.00	
00	SNF Excluded area salaries (see	44.00	0 10, 556, 081	15, 837, 168	26, 393, 24	0 0.00 9 459,978.00		
	instructions)		10, 000, 001	10,007,100	20, 070, 21	, 10,,,,,0.00	07.00	
	OTHER WAGES & RELATED COSTS		- 1/0 01/		5 4 (0.04			
00	Contract Labor: Direct Patient Care		5, 168, 916	0	5, 168, 91	6 44, 266. 00	116. 77	11
00	Contract Labor: Top Level		0	0		0.00	0.00	12
	management and other							
	management and administrative services							
00	Contract Labor: Physician-Part		134, 175	0	134, 17	5 751.00	178.66	13
	A - Administrative							
00	Home office and/or related organization salaries and		0	0		0 0.00	0.00	14
01	wage-related costs Home office salaries		0	0		0.00	0.00	14
	Related organization salaries		0	0		0 0.00		
00	Home office: Physician Part A		0	0		0.00	0.00	1!
00	- Administrative		0	0		0.00	0.00	14
00	Home office and Contract Physicians Part A - Teaching		0			0.00	0.00	1
01	Home office Physicians Part A		0	0		0.00	0.00	10
02	- Teaching Home office contract		0	0		0 0.00	0.00	1
02	Physicians Part A - Teaching		0	0		0 0.00	0.00	′ '`
	WAGE-RELATED COSTS			1		- 1		
00	Wage-related costs (core) (see		13, 154, 696	0	13, 154, 69	6		17
00	instructions) Wage-related costs (other)							18
	(see instructions)							
00	Excluded areas		5, 135, 756	0	5, 135, 75	6		19
	Non-physician anesthetist Part A Non-physician anesthetist Part		0					20 2'
	В							
00	Physician Part A - Administrative		72,060	0	72, 06	U		22
01	Physician Part A - Teaching		0	о		0		22
00	Physician Part B		570, 807	0	570, 80	7		23
	Wage-related costs (RHC/FQHC)		0	0		0		24
00	Interns & residents (in an approved program)		0	0		U		25
50	Home office wage-related		0	0		0		25
	(core)							
51	Related organization wage-related (core)		0	0		U		25
50	Home office: Physician Part A		0	0		0		25
52			0			1		

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part II	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARI		0	0		0		25.53
26.00		4.00	1, 208, 932	47, 966	1, 256, 89	8 31, 881. 00	39. 42	26.00
26.00	Employee Benefits Department Administrative & General	4.00 5.00	1, 208, 932					
28.00	Administrative & General under contract (see inst.)		1, 650, 579	0	1, 650, 57	9 14, 515. 00	113. 72	28.00
29.00	Maintenance & Repairs	6.00	0	0		0.00	0,00	29.00
30.00	Operation of Plant	7.00	890, 852	15, 679	906, 53	1 37, 242. 00		
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeepi ng	9.00	0	0		0,00		
33.00	Housekeeping under contract (see instructions)		1, 479, 829	0	1, 479, 82	9 105, 473. 00		
34.00	Dietary	10.00	20, 364	0	20, 36	4 313.00	65.06	34.00
35.00	Dietary under contract (see instructions)		428, 077	0	428, 07	7 24, 949. 98	17.16	35.00
36.00	Cafeteria	11.00	0	0		0 0.00	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, 504, 360	-373,000	1, 131, 36	0 19, 792. 00	57.16	38.00
39.00	Central Services and Supply	14.00	155, 304	22, 533	177, 83	7 8, 374.00	21. 24	39.00
40.00	Pharmacy	15.00	2,666,130					
41.00	Medi cal Records & Medi cal Records Li brary	16.00	0	0	, ,	0 0.00		41.00
42.00	Social Service	17.00	0	0		0 0.00	0.00	42.00
	Other General Service	18.00	0	0		0 0.00		43.00
				-				

Heal th	Financial Systems		MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part III Date/Time Pre 11/30/2022 9:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		58, 352, 367	22, 977, 748	81, 330, 11	5 1, 901, 555. 98	42.77	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 556, 081	15, 837, 168	26, 393, 24	9 459, 978. 00	57.38	2.00
	instructions)							
3.00	Subtotal salaries (line 1		47, 796, 286	7, 140, 580	54, 936, 86	6 1, 441, 577. 98	38. 11	3.00
	minus line 2)							
4.00	Subtotal other wages & related		5, 303, 091	0	5, 303, 09	1 45, 017. 00	117.80	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		13, 226, 756	0	13, 226, 75	6 0.00	24.08	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		66, 326, 133	7, 140, 580	73, 466, 71	3 1, 486, 594. 98	49.42	6.00
7.00	Total overhead cost (see		21, 188, 988			2 642, 882. 98	36.16	7.00
	instructions)							
		·				· ·	I	

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provi der	CCN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part IV Date/Time Pre 11/30/2022 9:	pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					1, 456, 126	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	uti on				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i	nstructions)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see inst	ructions)				2,000,000	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External O)rgani zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan					2, 073, 555	6.00
7.00	Employee Managed Care Program Administration	Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					0	8.00
8.01	Health Insurance (Self Funded without a Third					0	
8.02	Health Insurance (Self Funded with a Third Pa	arty Administrato	or)			6, 965, 448	
8.03	Health Insurance (Purchased)					0	
9.00	Prescription Drug Plan					0	
10.00	Dental, Hearing and Vision Plan					0	
11.00	Life Insurance (If employee is owner or benef					38, 380	
12.00	Accident Insurance (If employee is owner or b					0	
13.00	Disability Insurance (If employee is owner or					334, 489	
14.00		er or beneficiary	y)			0	
15.00	'Workers' Compensation Insurance					437, 574	
16.00	Retirement Health Care Cost (Only current yea	ar, not the extra	aordinary a	ccrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only					5, 458, 792	
18.00	Medicare Taxes - Employers Portion Only					0	
19.00	Unemployment Insurance						19.00
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than F instructions))	Retirement Cost P	Reported on	lines 1 thro	ugh 4 above. (see	0	21.00
22.00						0	
	Tuition Reimbursement					165, 140	
24.00	Total Wage Related cost (Sum of lines 1 -23)					18, 933, 324	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Health Financial Systems	MARION GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0011	Period: From 07/01/2021	Worksheet S-3 Part V	
		To 06/30/2022	Date/Time Pre	pared:
			11/30/2022 9:	15 am
Cost Center Description		Contract	Benefit Cost	
		Labor 1,00	2.00	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identi	fication			
1.00 Total facility's contract labor and benefit		5, 168, 916	18, 933, 324	1.00
2.00 Hospital	cost	5, 168, 916	18, 933, 324	2.00
3. 00 SUBPROVIDER - IPF		3, 100, 910	10, 755, 524	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 SKILLED NURSING FACILITY			-	8.00
9.00 NURSING FACILITY				9.00
10.00 OTHER LONG TERM CARE I				10.00
11.00 Hospital-Based HHA				11.00
12.00 AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00 Hospi tal -Based Hospi ce				13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospital-Based-CMHC				16.00
17.00 RENAL DIALYSIS I				17.00
18.00 Other		0	0	18.00

Heal th	Financial Systems MARION GENERAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
		Provider CC	CN: 15-0011	Peri od:	Worksheet S-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/30/2022 9:	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	n 8)	0. 253372	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				11, 554, 772	
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
	If line 3 is yes, does line 2 include all DSH and/or supplement			ai d?	N O	4.00 5.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments f Medicaid charges	rom medical	u		104, 899, 597	6.00
7.00	Medicaid cost (line 1 times line 6)				26, 578, 621	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of li	nes 2 and 5: if		•
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions f	or each lin	ie)		I	
	Net revenue from stand-al one CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus lino 0.	if < zero then		•
12.00	enter zero)		nus rine y,	ri < zero then	0	12.00
	Other state or local government indigent care program (see ins	tructions f	or each line)	I	
13.00	Net revenue from state or local indigent care program (Not inc	luded on li	nes 2, 5 or	9)	0	13.00
14.00	Charges for patients covered under state or local indigent car	e program (Not included	in lines 6 or	0	14.00
15 00						15 00
	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in		program (Li	no 15 minue ling	0	
10.00	13; if < zero then enter zero)	urgent care	program (ri		0	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and stat	e/local indi	gent care progra	ams (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to f					17.00
	Government grants, appropriations or transfers for support of			(C.I.I	0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16)	l indigent	care program	s (sum of lines	15, 023, 849	19.00
			Uni nsured	Insured	Total (col. 1	
		-	patients	patients	+ col. 2)	
	Uncomponented Care (see instructions for each line)		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	cility	9, 336, 14	4, 274, 121	13, 610, 268	20.00
20.00	(see instructions)	onney	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1, 2, 1, 121	10,010,200	20.00
21.00	Cost of patients approved for charity care and uninsured disco instructions)	unts (see	2, 365, 51	8 4, 274, 121	6, 639, 639	21.00
22.00	Payments received from patients for amounts previously written charity care	off as		0 174	174	22.00
23.00	Cost of charity care (line 21 minus line 22)		2, 365, 51	8 4, 273, 947	6, 639, 465	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	nt days bey	ond a length	of stay limit	1.00 N	24.00
	imposed on patients covered by Medicaid or other indigent care	program?	-			
25.00	If line 24 is yes, enter the charges for patient days beyond t stay limit	he indigent	care progra	m's length of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see in				8, 704, 083	
	Medicare reimbursable bad debts for the entire hospital comple	•			362, 740	
	Medicare allowable bad debts for the entire hospital complex (see instruc	ctions)		558,061	
28.00	Non-Medicare bad debt expense (see instructions)	nonco (coo	Instructions	\ \	8, 146, 022	
	Cost of non-Medicare and non-reimbursable Medicare bad debt ex Cost of uncompensated care (line 23 column 3 plus line 29)	heuze (zee	Instructions	J	2, 259, 295 8, 898, 760	
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			23, 922, 609	1
2.100					, ,, ,00,	

RECLAS	IFINANCIAL Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MARION GENERAL F EXPENSES	Provider C		In Lie eriod: rom 07/01/2021	u of Form CMS-2 Worksheet A	2552-10
					o 06/30/2022		
	Cost Center Description	Sal ari es	Other	Total (ool 1	Recl assi fi cat	11/30/2022 9: Recl assi fi ed	15 am
	cost center bescription	Salaries	othei	+ col. 2)	ions (See	Trial Balance	
					A-6)	(col . 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		12, 201, 800	12, 201, 800	-1, 268, 269	10, 933, 531	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 208, 932	17, 500, 624			18, 757, 522	
5.00	00500 ADMI NI STRATI VE & GENERAL	11, 184, 561	24, 300, 924			35, 267, 654	1
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	
6.01	00601 CAFETERI A	0	0	0	1, 652, 935	1, 652, 935	1
6.02	00602 CAFETERIA 00700 OPERATION OF PLANT	000 050	0	0	0	0	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	890, 852	5, 040, 501	5, 931, 353	392, 733 377, 850	6, 324, 086 377, 850	
9.00	00900 HOUSEKEEPI NG	0	3, 080, 819	3, 080, 819		2, 711, 975	
10.00	01000 DI ETARY	20, 364	2, 365, 528	2, 385, 892		685, 420	•
13.00	01300 NURSING ADMINISTRATION	1, 504, 360	84, 902	1, 589, 262		1, 216, 262	
14.00	01400 CENTRAL SERVICES & SUPPLY	155, 304	392, 276			570, 113	•
15.00	01500 PHARMACY	2, 666, 130	13, 073, 339	15, 739, 469	-11, 884, 117	3, 855, 352	15.00
30.00	03000 ADULTS & PEDIATRICS	9, 369, 025	2, 652, 924	12, 021, 949	-1, 441, 710	10, 580, 239	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 711, 734	1, 862, 648		-43, 835	4, 530, 547	31.00
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	
41.00	04100 SUBPROVI DER – I RF	1, 222, 933	901, 015	2, 123, 948	9, 985	2, 133, 933	•
42.00 43.00	04200 SUBPROVI DER	0	0	0	1 722 400	0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	U	0	0	1, 732, 409	1, 732, 409	43.00
50.00	05000 OPERATING ROOM	3, 261, 892	8, 685, 606	11, 947, 498	307, 937	12, 255, 435	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 416, 873	2, 270, 212	5, 687, 085		4, 749, 045	•
57.00	05700 CT SCAN	0	0	0	910, 074	910, 074	•
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0 806, 592	0 1, 692, 457	0 2, 499, 049	494, 875 39, 365	494, 875 2, 538, 414	•
60.00	06000 LABORATORY	2, 355, 388	6, 592, 759			8, 965, 232	•
60.01	06001 ONCOLOGY	1,007,860	603, 177	1, 611, 037	5, 719	1, 616, 756	1
60. 02	06002 RADI ATI ON ONCOLOGY	0	0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00		1,678,774	1, 208, 922	2, 887, 696		2, 967, 963	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	1, 932, 477 941, 366	277, 676 155, 780	2, 210, 153 1, 097, 146		2, 284, 973 1, 187, 003	
69.01	06901 CARDI AC REHAB	150, 200	46, 072	196, 272	32, 383	228, 655	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	11, 891, 348	11, 891, 348	73.00
00 00	OUTPATI ENT SERVICE COST CENTERS	260, 768	621, 629	882, 397	58, 095	940, 492	00 00
	09100 EMERGENCY	4, 768, 790	7, 764, 208				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	.,,	.,,	,,	,		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
05 00	OTHER REIMBURSABLE COST CENTERS	1 007 000	050.010	4 570 000	40.744	1 (01 050	05 00
95.00	09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	1, 227, 328	350, 910	1, 578, 238	43, 714	1, 621, 952	95.00
113.00	D11300 I NTEREST EXPENSE		0	0	0	0	113.00
118.00		52, 742, 503	113, 726, 708		24, 719	166, 493, 930	
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 050	10, 050	22, 541		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	140 774	020 500	0 1, 001, 282	0		192.00
	1 19201 PACT REV PHYSICIANS 2 19202 VISITOR MEALS	162, 774	838, 508	1, 001, 282	-229, 637	771, 645	192.01
	3 19203 GREAT BEGI NNI NGS/MATERNAL	16, 047	505	16, 552	0		192.02
	4 19204 LI FELI NE	0	0	0	0		192.04
	19205 OWNED PROPERTIES	0	1, 720, 878				
	19206 UROLOGY	371, 911	1, 076, 093	1, 448, 004	44, 075	1, 492, 079	
	7 19207 PHYSICIANS' PRIVATE OFFICES 3 19211 PARISH NURSING	0 54, 397	0 7,067	0 61, 464	8, 298		192.07 192.08
	19212 BI OTERRORI SM GRANT	54, 377	7,007	01, 404	0, 290		192.08
	19214 BREAST PUMPS	0	0	0	0		192.10
192. 1 [.]	19208 MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
	2 19209 LUNG CENTER	128, 910	673, 434				•
	19213 MGH EXPRESS	612, 415	978, 696		46, 923	1, 638, 034	•
	19210 MGH PHYS PRACT MGMT 19215 MGH MARION SURGEONS	1, 487, 873 484, 753	1, 365, 126 1, 664, 239	2, 852, 999 2, 148, 992		2, 939, 832 2, 226, 908	•
	19215 MGH MARTON SURGEONS 519216 MGH MGH MED ONC	484, 753 8, 857	1, 462, 592			1, 471, 449	
	19217 MGH FMC SOUTH	617, 238	1, 306, 078			2, 274, 417	
192.18	19218 MGH FAIRM MED ASSOC	128, 382	225, 581	353, 963	22, 271	376, 234	192. 18
192.19	9 19219 MGH FMC MARION 9 19300 NONPALD WORKERS	468, 739	1,011,443			1, 546, 564	
		0	0	0	0	· ∩	193.00

Health Financial Systems	MARI ON GENERAL		CN 15 0011			eu of Form CMS-2552-10 Worksheet A	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	E OF EXPENSES	Provider C	UN: 15-0011	Period: From 07/01/2021	WORKSNEET A		
			1	Го 06/30/2022	11/30/2022 9:		
Cost Center Description	Sal ari es	Other		Recl assi fi cat	Recl assi fi ed		
			+ col. 2)	ions (See	Trial Balance		
				A-6)	(col. 3 +-		
	1.00			1.00	col . 4)		
102 01 10201 NOL ENC NODTHWOOD	1.00	2.00	3.00	4.00	5.00	102.01	
193. 01 19301 MGH FMC NORTHWOOD	390, 447	851, 196					
193. 02 19302 MGH FMC GAS CITY	309, 090	708, 801			1, 095, 152		
193. 03 19303 MGH HOSPI TALI STS	63, 467	3, 470, 803					
193. 04 19304 MGH MAR FAM PRACT	1, 186, 685	2, 503, 356					
193. 05 19305 MGH FMC SWAYZEE	84, 123	161,016					
193. 06 19306 MGH PEDIATRIC CTR	236, 230	656, 308					
193. 07 19307 MGH SPECIALTY PHYS	66, 180	256, 898			337, 949		
193. 08 19308 MGH FMC CONVERSE	123, 498	256, 073			379, 878		
193. 09 19309 MGH UPLAND HEALTH	0	0	(193.09	
193. 10 19310 MGH MGH WOMENS CTR	0	0	(0		193.10	
193. 11 19311 MGH MGH PSYCHIATRY	0	0	0 500 040	0		193.11	
193. 12 19312 OB/GYN	503, 161	2, 090, 182					
193. 15 19315 MGH RIVER VIEW BLDG	0	0		0		193.15	
193. 16 19316 MGH NEONATOLOGY	0	888,000			888,000		
193. 18 19318 MGH WOUND CARE	0	26, 634			26, 634		
194.00 07963 HEART FAILURE CLINIC	0	55, 287			55, 287		
194. 01 07950 MOW	0	0	(194.01	
194. 02 07951 MENTAL HEALTH	0	0	(-		194.02	
194. 03 07952 ADVERTI SI NG	0	0	(
194. 04 07953 MGH WORK SOLUTIONS	288, 886	427, 113	715, 999				
194. 05 07954 MGH TAYLOR UNIVERSITY	0	0	(0 0		194.05	
194. 06 07955 OPI OI D I MPL GRANT	42, 652	391, 864			441, 720		
194. 07 07956 ASTHMA GRANT	0	0	(,		194.07	
194.08 07957 MGH SMMP BLDG	0	0	(0 0		194.08	
194. 09 07958 MGH AMBUCARE BLDG	0	0	(0 0		194.09	
194. 10 07959 MGH 106 LYONS BLDG	0	0	(0 0		194.10	
194. 11 07960 FAI RMOUNT	0	0		0		194.11	
194. 12 07961 GAS_CITY	0	0	(0		194.12	
194. 13 07969 LYONS	0	0	(0 0		194.13	
194. 14 07964 WABASH	0	0	()	5		194.14	
194. 15 07965 TOBACCO GRANT	34, 708	26, 080			65, 345		
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0				194.16	
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0		-		194.17	
194. 18 07962 ECHO GRANT	1, 924	26, 015			27, 939		
194. 19 07968 RURAL QI GRANT	25, 334	49, 806			75, 140		
194. 20 07970 MGH DI ABETES GRANT	0	0	(194.20	
194. 21 07971 MGH MGH ORTHO	0	0	(,		194.21	
194. 22 07972 MGH BELLA BLDG	0	0) (-		194.22	
194. 23 07973 DI ABETES GRANT	0	8, 779	8, 779			194.23	
194. 24 07974 HEALTH SYS GRANT	0	0	(0		194.24	
194. 25 07975 MGH MGH ORTHO	207, 139	1, 216, 549			1, 354, 081		
200.00 TOTAL (SUM OF LINES 118 through 199)	60, 848, 323	140, 137, 758	200, 986, 08	0	200, 986, 081	1200.00	

CLASSI	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	► EXPENSES	Provider CCN	15-0011	Period: From 07/01/2021	Worksheet A
					To 06/30/2022	Date/Time Prepare
	Cost Center Description	Adjustments	Net Expenses			11/30/2022 9:15 a
		(See A-8)	For Allocation			
		6.00	7.00			
	ENERAL SERVICE COST CENTERS	(7.0/0	10.0((.171			
	0100 NEW CAP REL COSTS-BLDG & FIXT 0400 EMPLOYEE BENEFITS DEPARTMENT	-67, 360 -2, 185, 927				1
	0500 ADMI NI STRATI VE & GENERAL	-11, 490, 264				5
	0600 MAINTENANCE & REPAIRS	0				6
1 0	0601 CAFETERI A	-5, 038	1, 647, 897			6
	0602 CAFETERIA	0	-			6
	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE	-174, 685 -3, 478				7
	0900 HOUSEKEEPI NG	-61				9
	1000 DI ETARY	-1,079				10
	1300 NURSI NG ADMI NI STRATI ON	-14				13
	1400 CENTRAL SERVICES & SUPPLY	-762				14
_	1500 PHARMACY NPATIENT ROUTINE SERVICE COST CENTERS	-31, 526	3, 823, 826			15
	3000 ADULTS & PEDIATRICS	-13,003	10, 567, 236			30
00 0	3100 I NTENSI VE CARE UNI T	-1, 724				31
	4000 SUBPROVI DER – I PF	0				40
	4100 SUBPROVI DER – I RF	-76, 319				41
	4200 SUBPROVI DER 4300 NURSERY	0				42
	NCILLARY SERVICE COST CENTERS		1,702,107			
	5000 OPERATING ROOM	-3, 715, 038				50
	15100 RECOVERY ROOM 15400 RADI OLOGY-DI AGNOSTI C	0 -155, 502	-			51
	5700 CT SCAN	- 155, 502				57
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0				58
	5900 CARDI AC CATHETERI ZATI ON	-197, 295				59
	6000 LABORATORY	-95, 465				60
1	6001 ONCOLOGY 6002 RADI ATI ON ONCOLOGY	-1, 305 0				60 60
	6400 I NTRAVENOUS THERAPY	0				64
	6500 RESPI RATORY THERAPY	-3,069	2, 964, 894			65
	6600 PHYSI CAL THERAPY	-146				66
	6900 ELECTROCARDI OLOGY 6901 CARDI AC REHAB	-53, 720 -55				69 69
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-55				71
	7200 I MPL. DEV. CHARGED TO PATIENTS	0				72
	7300 DRUGS CHARGED TO PATIENTS	0	11, 891, 348			73
	UTPATI ENT SERVI CE COST CENTERS	-1,003	939, 489			00
	19000 CEINIC 19100 EMERGENCY	-4, 863, 278				90
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	.,,	.,,			92
01 0	9201 OBSERVATION BEDS (DISTINCT PART)	0	0			92
	THER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	-56, 178	1, 565, 774			95
	PECIAL PURPOSE COST CENTERS	-30, 178	1, 505, 774			93
	1300 INTEREST EXPENSE	0				113
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-23, 193, 294	143, 300, 636			118
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 591			190
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0				192
	9201 PACT REV PHYSICIANS	-13, 209	758, 436			192
	9202 VI SI TOR MEALS	0	0			192
	9203 GREAT BEGI NNI NGS/MATERNAL 9204 LI FELI NE	0	16, 552 0			192 192
	9205 OWNED PROPERTIES	0	543, 523			192
	9206 UROLOGY	-63, 237				192
	9207 PHYSI CI ANS' PRI VATE OFFI CES	0	0			192
	9211 PARI SH NURSI NG 9212 BI OTERRORI SM GRANT	0	69, 762			192 192
	9212 BEOTERRORTSM GRANT 9214 BREAST PUMPS	0	0			192
	9208 MGH EMERGENCY PHYSICIANS	0	Ő			192
12 1	9209 LUNG CENTER	-51, 844				192
	9213 MGH EXPRESS	0	1, 638, 034			192
	9210 MGH PHYS PRACT MGMT	-68, 347				192
. 10 1	9215 MGH MARION SURGEONS 9216 MGH MGH MED ONC	-121,020				192 192
16 1		Ŭ				192
	9217 MGH FMC SOUTH	-359, 568	1,914.049			11.72
. 17 1 . 18 1	9218 MGH FAIRM MED ASSOC	-29, 094	347, 140			192
. 17 1 . 18 1 . 19 1			347, 140			

Health Financial Systems	MARI ON GENER	αι μοςρίται		In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provi der CC	N. 15-0011	Peri od:	Worksheet A		
				From 07/01/2021			
				To 06/30/2022			
					11/30/2022 9:15 am		
Cost Center Description	Adjustments	Net Expenses					
	(See A-8)	For					
	(00	Allocation					
	6.00	7.00			102.02		
193.02 19302 MGH FMC GAS CITY	-155, 446				193.02		
193. 03 19303 MGH HOSPI TALI STS	0				193.03		
193.04 19304 MGH MAR FAM PRACT	-199, 994				193.04		
193. 05 19305 MGH FMC SWAYZEE	-26, 352				193.05		
193. 06 19306 MGH PEDIATRIC CTR	-70, 866				193.06		
193. 07 19307 MGH SPECIALTY PHYS	-26, 634				193.07		
193.08 19308 MGH FMC CONVERSE	0	0.1,0.0			193.08		
193.09 19309 MGH UPLAND HEALTH	0	-			193.09		
193.10 19310 MGH MGH WOMENS CTR	0	0			193.10		
193.11 19311 MGH MGH PSYCHLATRY	0	0			193. 11		
193. 12 19312 OB/GYN	-198, 349	2, 578, 590			193.12		
193.15 19315 MGH RIVER VIEW BLDG	0	-			193.15		
193.16 19316 MGH NEONATOLOGY	0	888, 000			193.16		
193.18 19318 MGH WOUND CARE	0	26, 634			193. 18		
194.0007963 HEART FAILURE CLINIC	0	55, 287			194.00		
194. 01 07950 MOW	0	0			194.01		
194.0207951 MENTAL HEALTH	0	0			194.02		
194. 03 07952 ADVERTI SI NG	0	145, 569			194.03		
194.0407953 MGH WORK SOLUTIONS	0	720, 485			194.04		
194.0507954 MGH TAYLOR UNIVERSITY	0	0			194.05		
194.06079550PIOLDIMPL GRANT	0	441, 720			194.06		
194.0707956 ASTHMA GRANT	0	0			194.07		
194.0807957 MGH SMMP BLDG	0	0			194.08		
194.0907958 MGH AMBUCARE BLDG	0	0			194.09		
194.1007959 MGH 106 LYONS BLDG	0	0			194.10		
194. 11 07960 FAI RMOUNT	0	0			194.11		
194. 12 07961 GAS CI TY	0	0			194.12		
194. 13 07969 LYONS	0	0			194.13		
194. 14 07964 WABASH	0	0			194, 14		
194. 15 07965 TOBACCO GRANT	0	65, 345			194.15		
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0			194.16		
194. 17 07967 HRSA OPI OLD PLANNING	0	0			194.17		
194. 18 07962 ECHO GRANT	0	27, 939			194. 18		
194. 19 07968 RURAL QI GRANT	0				194.19		
194. 20 07970 MGH DI ABETES GRANT	0	, 0, 110			194.20		
194. 21 07971 MGH MGH ORTHO	0	0			194. 21		
194. 22 07972 MGH BELLA BLDG	0	0			194. 22		
194. 23 07973 DI ABETES GRANT	0	-			194.23		
194. 24 07974 HEALTH SYS GRANT	0				194.23		
194. 25 07975 MGH MGH ORTHO	0	-			194.24		
200.00 TOTAL (SUM OF LINES 118 through 199)	-24, 737, 954				200.00		
200.00 TITLE (JUNI OF LINES FID LIFUUGH 199)	-24, /3/, 734	1 170, 240, 127			1200.00		

	Financial Systems SIFICATIONS		MARION GENERA	L HOSPITAL Provider CCN:	15-0011	Period:	eu of Form CMS-255 Worksheet A-6
						From 07/01/202 To 06/30/2022	2 Date/Time Prepa
		Increases					11/30/2022 9:15
	Cost Center	Line #	Sal ary	Other			
		3.00	4.00	5.00			
00	A - SATELLITE OFFICE RECLASS RADIOLOGY-DIAGNOSTIC	54.00	64, 143	10, 911			
00	ELECTROCARDI OLOGY	69.00	4, 187	632			
00	TOTALS		68, 330	11, 543			
	B - CAFETERIA RECLASS						
00	ADMI NI STRATI VE & GENERAL	5.00	0	76, 453			
00	<u>CAFETERI A</u>	<u> </u>	0	<u>1, 652, 9</u> 35			
	TOTALS		0	1, 729, 388			
00	C - ADMIN DIRECTOR RECLASS CENTRAL SERVICES & SUPPLY	14.00	17, 831	0			
00	ADULTS & PEDIATRICS	30.00	262, 024	0			
0	OPERATI NG ROOM	50.00	116,006	0			
00	CARDI AC CATHETERI ZATI ON	59.00	34,004	0			
00	RESPI RATORY THERAPY	65.00	59, 728	0			
00	ELECTROCARDI OLOGY	69.00	68, 007	0			
00	CARDI AC REHAB	69.01	17,002	0			
00	AMBULANCE SERVICES	95.00	33, 469	0			
00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	22, 541	0			
00	PARI SH NURSI NG	192.08	4, 239	0			1
00	MGH EXPRESS	192.13	41,837	Ő			1
00	OB/GYN	193. 12	61, 484	0			1
	TOTALS		738, 172	0			
	D - ADVERTISING RECLASS						
00	ADVERTISING	194.03	132, 574	<u>12, 995</u>			
			132, 574	12, 995			
00	E - LEASED PROPERTY RECLASS ADMINI STRATI VE & GENERAL	5.00		119, 182			
00	OPERATION OF PLANT	7.00		375, 444			
0	HOUSEKEEPING	9.00		8, 653			
00	DI ETARY	10.00		28, 319			
00	OPERATING ROOM	50.00		180, 267			
00	RADI OLOGY-DI AGNOSTI C	54.00		284, 094			
00	CT SCAN	57.00		20, 127			
00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		22, 698			
00	LABORATORY	60.00		91, 550			
00	RESPI RATORY THERAPY	65.00		20, 539			1
00	PHYSI CAL THERAPY	66.00		55, 896			1
	ELECTROCARDI OLOGY	69.00		17, 031			1
00	CARDI AC REHAB	69.01		15, 381			1
00		90.00		58, 095			1
	PACT REV PHYSI CLANS	192.01		9, 222 44, 075			1
	UROLOGY PARI SH NURSI NG	192. 06 192. 08		44,075			1
00	LUNG CENTER	192.08		4, 059 30, 106			1
00	MGH EXPRESS	192.12		5, 086			1
00	MGH PHYS PRACT MGMT	192.14		47, 278			2
00	MGH MARION SURGEONS	192.15		77, 916			2
00	MGH FMC SOUTH	192.17		326, 244			2
00	MGH FAI RM MED ASSOC	192.18		22, 271			2
00	MGH FMC MARION	192.19		66, 382			2
00	MGH FMC NORTHWOOD	193.01		26, 070 77 - 261			2
	MGH FMC GAS CITY MGH MAR FAM PRACT	193. 02 193. 04		77, 261 98, 200			2
00 00	MGH MAR FAM PRACT MGH FMC SWAYZEE	193.04 193.05		98, 200 26, 366			2
00	MGH PEDIATRIC CTR	193.05		62, 790			2
00	MGH SPECIALTY PHYS	193.07		14, 871			3
00	MGH FMC CONVERSE	193.08		307			3
00	OB/GYN	193. 12		122, 112			3
00	MGH WORK SOLUTIONS	194.04		4, 486			3
00	OPIOID IMPL GRANT	194.06		7,204			3
00	TOBACCO GRANT	1 <u>94.</u> 15		4, 557			3
	TOTALS F - PHARMACY RECLASS		0	2, 374, 139			
00	P - PHARMACY RECLASS	73.00		11, 891, 348			
	TOTALS		— — — ₀	11, 891, 348			
	G - CT/MRI RECLASS			, 57.1, 510			
00	CT SCAN	57.00	533, 758	354, 636			
	MAGNETIC RESONANCE IMAGING	58.00	282, 638	187, 788			
00	(MRI)						

EULAS	SI FI CATI ONS			Provider CCN: 15-00	From 07/01/2021	Worksheet A-6
					To 06/30/2022	Date/Time Prepared: 11/30/2022 9:15 am
	Cost Center	Increases Line #	Salary	Other		
	2.00	3.00	Salary 4.00	5.00		
	H - SHORT TERM DI SABI LI TY REC			0100		
. 00	ADMI NI STRATI VE & GENERAL	5.00		5, 968		1.00
00	ADULTS & PEDIATRICS	30.00		10, 945		2.00
00 00	ONCOLOGY ELECTROCARDI OLOGY	60. 01 69. 00		11, 466 171		3.00
. 00	MGH PHYS PRACT MGMT	192.14		2, 776		5.00
00	TOTALS		0	31, 326		
	I - NURSERY RECLASS		L.			
. 00	NURSERY	43.00	1, 457, 910	274, 499		1.00
	TOTALS J - SMMP HOUSEKEEPING RECLASS		1, 457, 910	274, 499		
00	ADMI NI STRATI VE & GENERAL	5.00		15, 690		1.00
00	OPERATION OF PLANT	7.00		1, 610		2.00
00	HOUSEKEEPI NG	9.00		353		3.00
00	DI ETARY	10.00		597		4.00
. 00	RADI OLOGY-DI AGNOSTI C	54.00		22, 265		5.00
00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00 58.00		1, 553 1, 751		6.00
00	(MRI)	58.00		1,751		7.00
00	LABORATORY	60.00		2, 809		8.00
. 00	MGH FMC SOUTH	1 <u>92.</u> 17	⊥	24,857		9.00
	TOTALS		0	71, 485		
00	K - LAUNDRY RECLASS	8.00	0	377, 850		1.00
. 00	LAUNDRY & LINEN SERVICE		0	377,850		1.00
	L - PHYSICIAN MEDICAL DIRECTO	R RECLASS		377,000		
00	ADMI NI STRATI VE & GENERAL	5.00	238, 859	0		1.00
	TOTALS		238, 859	0		
	M - PHYSICIAN SALARY RECLASS		0.000.0/1			
00	ADMI NI STRATI VE & GENERAL SUBPROVI DER – I RF	5.00 41.00	2, 829, 261 68, 502	0		1.00
00	RESPI RATORY THERAPY	65.00	6, 103	0		3.00
00	PHYSI CAL THERAPY	66.00	4, 255	0		4.00
00	CARDI AC REHAB	69.01	11, 347	0		5.00
. 00	EMERGENCY	91.00	4, 479, 391	0		6.00
. 00	PACT REV PHYSI CI ANS	192.01	709, 107	0		7.00
00	UROLOGY LUNG CENTER	192.06 192.12	616, 036 550, 143	0		8.00
0.00	MGH EXPRESS	192.12	563, 466	0		10.00
1.00	MGH MARION SURGEONS	192. 15	1, 349, 628	0		11.00
2.00	MGH MGH MED ONC	192.16	1, 312, 754	0		12.00
3.00	MGH FMC SOUTH	192.17	703, 345	0		13.00
4.00	MGH FAI RM MED ASSOC	192.18	123, 318	0		14.00
5.00 6.00	MGH FMC MARION MGH FMC NORTHWOOD	192. 19 193. 01	677, 996 587, 597	0		15.00 16.00
7.00	MGH FMC GAS CITY	193.01	323, 924	0		17.00
8.00	MGH HOSPI TALI STS	193.03	3, 098, 170	0		18.00
9.00	MGH MAR FAM PRACT	193. 04	1, 651, 333	0		19.00
D. 00	MGH FMC SWAYZEE	193.05	103, 044	0		20.00
1.00	MGH PEDIATRIC CTR	193.06	419, 856	0		21.00
2.00 3.00	MGH SPECIALTY PHYS MGH FMC CONVERSE	193. 07 193. 08	186, 709 124, 360	0		22.00
4.00	OB/GYN	193. 12	1, 358, 614	0		23.00
5.00	MGH WOUND CARE	193.18	23, 985	0		25.00
5.00	HEART FAILURE CLINIC	194.00	36, 279	0		26.00
7.00	MGH WORK SOLUTIONS	194. 04	109, 135	0		27.00
8.00	MGH MGH ORTHO	<u> </u>	981, 416	0		28.00
	TOTALS N - LIABILITY INSURANCE RECLA	22	23, 009, 074	0		
00	ADMI NI STRATI VE & GENERAL	5.00		69, 607		1.00
	TOTALS		0	69,607		
	0 - MANAGEMENT BONUS RECLASS					
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	47, 966	0		1.00
. 00	OPERATION OF PLANT	7.00	15, 679	0		2.00
00	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY	13.00 14.00	203, 358 4, 702	0		3.00
00	PHARMACY	14.00	7, 231	0		4.00
00	ADULTS & PEDIATRICS	30.00	28, 675	0		6.00
00	INTENSIVE CARE UNIT	31.00	15, 893	0		7.00
. 00	SUBPROVIDER - IRF	41.00	9, 985	0		8.00
. 00	OPERATING ROOM	50.00	11,664	0		9.00
0.00 1.00	RADI OLOGY-DI AGNOSTI C CARDI AC CATHETERI ZATI ON	54.00 59.00	39, 367 5, 361	0		10.00
1.00	LABORATORY	60. 00	2, 599	0		12.00

Heal th	Financial Systems		MARI ON GENER	AL HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provider (CCN: 15-0011	Period:	Worksheet A-	6
						From 07/01/2021 To 06/30/2022	Date/Time Pr 11/30/2022 9	epared: 0:15 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
13.00	ONCOLOGY	60. 01	5, 719	0				13.00
14.00	PHYSI CAL THERAPY	66.00	18, 924	0				14.00
15.00	EMERGENCY	91.00	54, 193	0				15.00
16.00	AMBULANCE SERVICES	95.00	10, 245	0				16.00
17.00	MGH PHYS PRACT MGMT	192.14	39, 555	0				17.00
18.00	MGH HOSPITALISTS	193. 03	44, 157	0				18.00
	TOTALS		565, 273	0				
500.00	Grand Total: Increases		27, 026, 588	17, 386, 604				500.00

	Financial Systems SIFICATIONS		MARION GENERAL		CCN: 15-0011	In Lie Period:	u of Form CMS-2552-10 Worksheet A-6
RECERS					50N. 15-0011	From 07/01/2021 To 06/30/2022	
	Cost Center	Decreases Line #	Salary		Wkst. A-7 Ref		
1.00	6.00 A - SATELLITE OFFICE RECLASS	7.00	8.00	9.00	10.00		1.00
1.00 2.00	LABORATORY	60.00 0.00	68, 330 0	11, 543 0	(1.00 2.00
	TOTALS B - CAFETERIA RECLASS		68, 330	11, 543			
1.00 2.00	DI ETARY	10. 00 0. 00	0	1, 729, 388 0			1.00 2.00
2.00			<u>0</u>	1, 729, 388			
1.00	C – ADMIN DIRECTOR RECLASS ADMINISTRATIVE & GENERAL	5.00	26, 780	0		D	1.00
2.00 3.00	NURSING ADMINISTRATION	13.00 31.00	576, 358 59, 728	0			2.00
4.00	EMERGENCY	91.00	75, 306	0	(b	4.00
5.00 6.00		0.00 0.00	0	0 0			5. 00 6. 00
7.00 8.00		0. 00 0. 00	0	0			7.00
9.00		0.00	0	0	(b	9.00
10. 00 11. 00		0.00 0.00	0	0 0			10.00 11.00
12.00		0.00	00 738, 172	00		2	12.00
1 00	D - ADVERTISING RECLASS	5.00					
1.00	ADMI NI STRATI VE & GENERAL TOTALS	5.00	<u>132, 5</u> 74 132, 574	1 <u>2, 9</u> 95 12, 995			1.00
1.00	E - LEASED PROPERTY RECLASS NEW CAP REL COSTS-BLDG &	1.00	0	1, 268, 269	1		1.00
	FIXT		-				
2.00 3.00	OWNED PROPERTIES	192. 05 0. 00	0 0	1, 105, 870 0	(2.00 3.00
4.00 5.00		0. 00 0. 00	0	0			4.00
6.00		0.00	Ō	0	(C	6.00
7.00 8.00		0.00 0.00	0	0 0	(7.00 8.00
9.00 10.00		0. 00 0. 00	0	0			9.00
11.00		0.00	0	0	(c	11.00
12. 00 13. 00		0.00 0.00	0	0 0			12.00 13.00
14.00 15.00		0. 00 0. 00	0	0 0			14.00 15.00
16.00		0.00	0	0	(16.00
17.00 18.00		0. 00 0. 00	0	0			17.00 18.00
19.00 20.00		0. 00 0. 00	0	0			19.00 20.00
21.00		0.00	0	0	(C	21.00
22. 00 23. 00		0. 00 0. 00	0 0	0 0			22.00 23.00
24.00 25.00		0. 00 0. 00	0	0			24.00 25.00
26.00		0.00	0	0	(C	26.00
27.00 28.00		0.00 0.00	0	0 0			27.00 28.00
29.00 30.00		0.00 0.00	0	0			29.00 30.00
31.00		0.00	0	0			31.00
32.00 33.00		0. 00 0. 00	0	0 0			32.00 33.00
34.00 35.00		0.00 0.00	0	0			34.00 35.00
55.00		0.00	0	2, 374, 139			
1.00	F - PHARMACY RECLASS PHARMACY			<u>11, 891, 3</u> 48		<u>ב</u>	1.00
	TOTALS		0	11, 891, 348			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	816, 396	542, 424		2	1.00
2.00	TOTALS	0.00	0 816, 396	0 542, 424			2.00
1.00	H - SHORT TERM DI SABILITY REC ADMINI STRATIVE & GENERAL	LASS 5.00	5, 968	0			1.00
2.00	ADULTS & PEDIATRICS	30.00	10, 945	0	(b	2.00
3.00	ONCOLOGY	60.01	11, 466	0	(0	3.00

	Financial Systems SIFICATIONS		MARION GENERAL		CCN: 15-0011	Period: From 07/01/2021 To 06/30/2022	
		Deerseese					11/30/2022 9:15 am
	Cost Center	Decreases Li ne #	Salary	Other	Wkst. A-7 Ref	.	
	6. 00	7.00	8.00	9.00	10.00		
4.00	ELECTROCARDI OLOGY	69.00	171	0		0	4.00
5.00	MGH PHYS PRACT MGMT	<u> </u>	<u>2, 776</u> 31, 326	0		<u>0</u>	5.00
	I - NURSERY RECLASS						
1.00	ADULTS & PEDI ATRI CS		1, 457, 910	274, 499	<u> </u>	이	1.00
	TOTALS J - SMMP HOUSEKEEPING RECLASS	<u> </u>	1, 457, 910	274, 499			
1.00	OWNED PROPERTIES	192.05	0	71, 485	i	0	1.00
2.00		0.00	0	0		0	2.00
3.00 4.00		0. 00 0. 00	0	0		0	3.00 4.00
5.00		0.00	0	0		0	5.00
6.00		0.00	0	0		0	6.00
7.00 8.00		0. 00 0. 00	0	0		0	7.00 8.00
9.00		0.00	0 0	0		0	9.00
	TOTALS		0	71, 485		1	
1.00	K - LAUNDRY RECLASS HOUSEKEEPING	9.00	0	377, 850		0	1.00
1.00	TOTALS		— — — 0			1	1.00
	L - PHYSICIAN MEDICAL DIRECTO		-		1	-	
1.00	PACT_REV_PHYSICIANS	1 <u>92.</u> 01	238,859	0		o	1.00
	M - PHYSICIAN SALARY RECLASS		238, 859	0	1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 829, 261		0	1.00
2.00	SUBPROVIDER - IRF	41.00	0	68, 502		0	2.00
3.00 4.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	6, 103 4, 255		0	3.00 4.00
5.00	CARDI AC REHAB	69.01	0 0	11, 347		0	5.00
6.00	EMERGENCY	91.00	О	4, 479, 391		0	6.00
7.00 8.00	PACT REV PHYSICIANS UROLOGY	192. 01 192. 06	0	709, 107 616, 036		0	7.00 8.00
8.00 9.00	LUNG CENTER	192.08	0 0	550, 143		0	9.00
10.00	MGH EXPRESS	192. 13	0	563, 466		o	10.00
11.00	MGH MARION SURGEONS	192.15	0	1, 349, 628		0	11.00
12.00 13.00	MGH MGH MED ONC MGH FMC SOUTH	192. 16 192. 17	0	1, 312, 754 703, 345		0	12.00 13.00
14.00	MGH FAIRM MED ASSOC	192.18	Ō	123, 318		0	14.00
15.00	MGH FMC MARION	192.19	0	677, 996		0	15.00
16.00 17.00	MGH FMC NORTHWOOD MGH FMC GAS CITY	193. 01 193. 02	0	587, 597 323, 924		0	16.00 17.00
18.00	MGH HOSPITALISTS	193. 02	0 0	3, 098, 170		0	18.00
19.00	MGH MAR FAM PRACT	193. 04	0	1, 651, 333		0	19.00
20.00 21.00	MGH FMC SWAYZEE MGH PEDIATRIC CTR	193. 05 193. 06	0	103, 044 419, 856		0	20.00 21.00
21.00	MGH SPECIALTY PHYS	193.00	0	186, 709		0	21.00
23.00	MGH FMC CONVERSE	193. 08	О	124, 360		o	23.00
24.00	OB/GYN	193.12	0	1, 358, 614		0	24.00
25.00 26.00	MGH WOUND CARE HEART FAILURE CLINIC	193. 18 194. 00	0	23, 985 36, 279		0	25.00 26.00
27.00	MGH WORK SOLUTIONS	194.04	Ō	109, 135		0	27.00
28.00	MGH MGH ORTHO	1 <u>94.</u> 25	0	98 <u>1, 4</u> 16		Q	28.00
	TOTALS N - LIABILITY INSURANCE RECLA	ASS	U	23, 009, 074	•		
1.00	MGH MGH ORTHO	194.25		6 <u>9, 6</u> 07	·	0	1.00
	TOTALS		0	69, 607			
1.00	0 - MANAGEMENT BONUS RECLASS ADMINISTRATIVE & GENERAL	5.00	565, 273	0		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00 5.00		0. 00 0. 00	0	0		0	4.00 5.00
6.00		0.00	0	0		0	6.00
7.00		0.00	О	0		0	7.00
8.00		0.00	0	0		0	8.00
9.00 10.00		0. 00 0. 00	0	0 0		0	9.00 10.00
11.00		0.00	õ	0		0	11.00
12.00		0.00	0	0		0	12.00
13.00 14.00		0. 00 0. 00	U O	0		0	13.00 14.00
15.00		0.00	0	0		0	15.00
16.00		0.00	0	0		0	16.00
17.00		0.00	0	0		0	17.00

MCRI F32 - 17. 12. 175. 4

MARION GENERAL HOSPITAL In Lieu of Form CMS-2552-10

Heal th	Financial Systems		MARION GENERA	AL HOSPITAL		In Lieu	u of Form CMS	2552-10
RECLASS	FI CATI ONS			Provi der	CCN: 15-0011	Period: From 07/01/2021	Worksheet A-	6
							Date/Time Pr 11/30/2022 9	epared: 15 am
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
18.00		0.00	0	(D	0		18.00
	TOTALS		565, 273	(C			
500.00	Grand Total: Decreases		4, 048, 840	40, 364, 352	2			500.00

RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	N: 15-0011	Period:	u of Form CMS-2 Worksheet A-7	
					From 07/01/2021	Part I	
					To 06/30/2022		pared:
						11/30/2022 9:	15 am
				Acqui si ti on			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
~~	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		0 705 000		0 705 000		
1.00	Land	9,044,644	3, 725, 000		0 3, 725, 000		1.00
2.00	Land Improvements	3, 364, 440	4, 729		0 4, 729		2.00
3.00	Buildings and Fixtures	150, 475, 907	3, 808, 763		0 3, 808, 763		3.00
1.00	Building Improvements	2, 481, 340	0		0 0	1, 476, 832	4.0
5.00	Fixed Equipment	3, 509, 530	0		0 0	0	5.0
5.00	Movable Equipment	79, 288, 571	27, 154, 498		0 27, 154, 498		6.0
. 00	HIT designated Assets	0	0		0 0	0	7.0
3.00	Subtotal (sum of lines 1-7)	248, 164, 432	34, 692, 990		0 34, 692, 990		8.0
9.00	Reconciling Items	0	0		0 0	0	9.00
0.00	Total (line 8 minus line 9)	248, 164, 432	34, 692, 990		0 34, 692, 990	5, 868, 777	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		-				
. 00	Land	12, 769, 644	0				1.0
. 00	Land Improvements	3, 369, 169	0				2.0
3.00	Buildings and Fixtures	154, 284, 670	0				3.0
4.00	Building Improvements	1, 004, 508	0				4.0
5.00	Fixed Equipment	3, 509, 530	0				5.0
o. 00	Movable Equipment	102, 051, 124	0				6.0
7.00	HIT designated Assets	0	0				7.0
3.00	Subtotal (sum of lines 1-7)	276, 988, 645	0				8.0
9.00	Reconciling Items	0	0				9.0
10.00	Total (line 8 minus line 9)	276, 988, 645	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0011 Period: Worksheet A-7 From 07/01/2021 Part II To 06/30/2022 P:15 a	d:
To 06/30/2022 Date/Time Prepare	d: m
	m
	<u></u>
SUMMARY OF CAPITAL	
Cost Center Description Depreciation Lease Interest Insurance Taxes (see	
(see instructions)	
i instructions)	
9.00 10.00 11.00 12.00 13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2	
1.00 NEW CAP REL COSTS-BLDG & FIXT 12, 201, 800 0 0 0 1.	00
3.00 Total (sum of lines 1-2) 12,201,800 0 0 0 0 3.	00
SUMMARY OF CAPITAL	
Cost Center Description Other Total (1)	
Capital -Relat (sum of cols.	
ed Costs (see 9 through 14)	
instructions)	
14.00 15.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2	
	00
	00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 Fo 06/30/2022	Worksheet A-7 Part III Date/Time Pre 11/30/2022 9:	pared:
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
	1.00	2.00	<u>col.2)</u> 3.00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1.00	0.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	276, 988, 645	0	276, 988, 64	5 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	276, 988, 645	0	276, 988, 64	5 1.000000	0	3.00
	ALLOCATI ON OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other Capital-Relat	Total (sum of cols. 5	Depreciation	Lease	
		ed Costs	through 7)			
	6. 00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0			12, 201, 800		1.00
3.00 Total (sum of lines 1-2)	0	-		12, 201, 800	-1, 268, 269	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1	1		
1.00 NEW CAP REL COSTS-BLDG & FIXT	-67, 360			0 0		1.00
3.00 Total (sum of lines 1-2)	-67, 360	0	(0 0	10, 866, 171	3.00

Health Financial Systems MARION GENERAL HOSPITAL
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	Financial Systems		MARI ON GENERAL			u of Form CMS-2	
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0011 Period: From 07/01/2 To 06/30/2			/2022 Date/Time Pre 11/30/2022 9:	
			Т	Expense Classification on o/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			EW CAP REL COSTS-BLDG & IXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0 *	** Cost Center Deleted ***	2.00	0	2.00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3.00
1. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
5.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0. 00	0	7.00
3.00	Television and radio service (chapter 21)		0		0.00	о	8.00
7.00 10.00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -8, 867, 551		0. 00	0	9.00 10.00
	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.00
2.00	(chapter 23) Related organization	A-8-1	0			0	12.00
13.00	transactions (chapter 10) Laundry and linen service	6	0		0.00	0	13.00
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee and others	В	-2, 400C 0	AFETERI A	6. 01 0. 00	0 0	14.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		О		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19.00
20.00	books, etc.) Vending machines		о		0.00	0	20.00
	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OP	HYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0*	** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL		ON	EW CAP REL COSTS-BLDG &	1.00	0	26.00
7.00	COSTS-BLDG & FIXT Depreciation - CAP REL			IXT ** Cost Center Deleted ***	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 *	** Cost Center Deleted ***	19. 00		28.00
29.00	Physicians'assistant		0		0.00	0	29.00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0*	** Cost Center Deleted ***	67.00		30.00
30. 99	Hospice (non-distinct) (see instructions)		OA	DULTS & PEDI ATRI CS	30. 00		30. 99

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

31. 00 32. 00 33. 00 33. 01	MENTS TO EXPENSES			Provider CCN: 15-0011 Pe Fr To Expense Classification on To/From Which the Amount is	Worksheet A	Worksheet A-8 Date/Time Pre 11/30/2022 9:	pared:
32.00 33.00 33.01	Cost Center Description			Expense Classification on	06/30/2022 Worksheet A	11/30/2022 9:	
32.00 33.00 33.01	Cost Center Description			Expense Classification on	Worksheet A	11/30/2022 9:	
32.00 33.00 33.01	Cost Center Description						
32.00 33.00 33.01	Cost Center Description			To/From Which the Amount is	to be Adjusted		
32.00 33.00 33.01	Cost Center Description				-		
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32.00 33.00 33.01	-	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
32.00 33.00 33.01		(2)				Ref.	<u> </u>
32.00 33.00 33.01		1.00	2.00	3.00	4.00	5.00	
33. 00 33. 01	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
33. 00 33. 01	pathology costs in excess of						
33. 00 33. 01	limitation (chapter 14)						
33.01	CAH HIT Adjustment for		0		0.00	0	32.00
33.01	Depreciation and Interest				5 00		
	FINANCE BANK SERVICE CHARGES	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	FINANCE DI SCOUNT PAYMENTS	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	GAIN ON DI SPOSAL	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.02
	XIX ASSESSMENT FEE A/C	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	SELF INSURANCE EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
	DEPOSI TI ON-OTHER	В		ADMI NI STRATI VE & GENERAL	5.00	0	
	RETURNED CHECK FEE	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.06
	PHYSICIAN PRIV APPLICATION	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33.08	SALE OF MEDICAL RECORDS &	В	- /1, 409	ADMINISTRATIVE & GENERAL	5.00	0	33.08
22 00	ABSTRACTS	п	25.0		F 00	<u>^</u>	22.00
33.09	CHILD SEAT SAFETY INSPECTION	В		ADMINISTRATIVE & GENERAL	5.00	0	
	HEALTH SCREENING FEES - LAB	В			60.00	0	33.10
	HEALTH SCREENING FEES - RAD	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33. 12	MED STAFF OTHER SCREENING -	В	0	ADMINISTRATIVE & GENERAL	5.00	0	33.12
00.40	MED STAF		0 544		(0.00		00.40
	HEALTH SCREENS	В			60.00	0	
	HEALTH SCREENS	В			60.00	0	33.14
	REBATE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
	REBATE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 17	RENTAL OF PROVIDER SPACE BY	В	-3, 392	ADMI NI STRATI VE & GENERAL	5.00	0	33.17
33. 18	SUPPLIER	В	0		40.00	0	33.18
	RENT SPACE UPLAND	В			60.00 5.00	0	•
33. 20	PAGER RENTAL	В		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00	0	
33.20	SALE OF SCRAP, WASTE, ETC. PCC MARKETING AG	B		ADMINISTRATIVE & GENERAL	5.00	0	•
	EDUCATIONAL WORKSHOP	B		ADMINISTRATIVE & GENERAL	5.00	0	•
33.22	OPT HEALTH LINEN SEV	B		LAUNDRY & LINEN SERVICE	8.00	0	
33.24	AMBULANCE SVC - ASSISTS	В		AMBULANCE SERVICES	95.00	0	
	AMBULANCE SVC - CORONER SVC	B		AMBULANCE SERVICES	95.00	0	33.25
	AMBULANCE SVC - LINEN SERVICES	B		AMBULANCE SERVICES	95.00	0	•
	AMBULANCE SVC - COMMUNITY	B		AMBULANCE SERVICES	95.00	0	•
	CONTRACT ARU OTH ARU MEDICAL	В		SUBPROVI DER – I RF	41.00	0	
55.20	DI RECTO	D	50, 275		41.00	0	35.20
33. 29	MGH UNCLAIMED OTH 125	В	-23 416	ADMI NI STRATI VE & GENERAL	5.00	0	33.29
00.27	MED/CHI LD	D	20, 110		0.00	0	00.27
33.30	SCHOOL PHYS OTHER SCHOOL PHYS	В	-7.980	ADMI NI STRATI VE & GENERAL	5.00	0	33.30
	PHLEBOTOMY	B		LABORATORY	60.00	0	
	CPR TRAIN OTH AHA COMMUNITY	B		ADMI NI STRATI VE & GENERAL	5.00	0	
	CLINICAL STUDY - OTHER	B		ONCOLOGY	60. 01	0	
	SICK CHILD CARE PROGRAM	В		ADULTS & PEDIATRICS	30.00	0	•
	ONC. QUAL	В		ADMINISTRATIVE & GENERAL	5.00	0	
	SETTLEMENTS	В	0	ADMI NI STRATI VE & GENERAL	5.00	0	33.36
	UNCLAIMED OTHER MONIES	В		ADMI NI STRATI VE & GENERAL	5.00	0	•
-	RECOVERED		-				
33.38	VENDING MACHINES	В	-2,638	CAFETERI A	6. 01	0	33.38
	MI SCELLANEOUS OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	•
	COVID OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	•
	DIABETES OTHER REVENUE	В		LABORATORY	60.00	0	1
	RENT BILLB OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	1
	STAT RADIOLOGY OTHER REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	1
	HEALTH SCREENINGS - FLU SHOT	В		LABORATORY	60.00	0	•
	MISC REV	В		ADMINISTRATIVE & GENERAL	5.00	0	33.45
	TELEVISION AND RADIO SERVICE	Α		OPERATION OF PLANT	7.00	0	33.46
	TELEPHONE SERVICES	Α		OPERATION OF PLANT	7.00	0	1
33. 48	OPERATING INTEREST INCOME	В		NEW CAP REL COSTS-BLDG &	1.00	11	33.48
ļ				FLXT			
33.49	LOBBYING COSTS	Α	-20	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.49
	LOBBYING COSTS	Α		ADMINISTRATIVE & GENERAL	5.00	0	33.50
33. 51	LOBBYING COSTS	A	-383	PHARMACY	15.00	0	33.51
33. 52	LOBBYING COSTS	А		RADI OLOGY-DI AGNOSTI C	54.00	0	33.52
	LOBBYING COSTS	A		ONCOLOGY	60. 01	0	33.53

		2552 10					
	Financial Systems MENTS TO EXPENSES		MARION GENER		Period:	u of Form CMS-2 Worksheet A-8	
ADJU31	MENTS TO EXPENSES				From 07/01/2021	WULKSHEEL A-0	
				-	Го 06/30/2022		
				Expense Classification or	Worksheet A	11/30/2022 9:	15 am
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
00 54		1.00	2.00	3.00	4.00	5.00	00.54
33. 54 33. 55	LOBBYING COSTS LOBBYING COSTS	A A		RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	33.54 33.55
33.55	ELIMINATING ENTRIES	A		MGH PHYS PRACT MGMT	192.14		33.55
33.57	ELIMINATING ENTRIES	A		MGH WORK SOLUTIONS	194.04	0	
33.58	ELIMINATING ENTRIES	А		LUNG CENTER	192.12	0	33.58
33.59	ELIMINATING ENTRIES	A		MGH MARION SURGEONS	192.15	0	33.59
33.60	ELIMINATING ENTRIES	A		MGH FMC SOUTH	192.17	0	33.60
33.61	ELIMINATING ENTRIES	A		MGH FAIRM MED ASSOC	192.18	0	33.61
33. 62 33. 63	ELIMINATING ENTRIES	A		MGH FMC MARION MGH FMC GAS CITY	192.19	0	33.62
33. 63 33. 64	ELIMINATING ENTRIES ELIMINATING ENTRIES	A A		MGH FMC GAS CITY MGH FMC SWAYZEE	193.02 193.05		33.63 33.64
33.65	ELIMINATING ENTRIES	A		MGH PEDIATRIC CTR	193.05		33.65
33.66	ELIMINATING ENTRIES	A		UROLOGY	192.06	0	33.66
33.67	ELIMINATING ENTRIES	А	-26, 634	MGH SPECIALTY PHYS	193.07	0	33.67
33.68	ELIMINATING ENTRIES	А		MGH FMC NORTHWOOD	193.01	0	33.68
	ELIMINATING ENTRIES	A		MGH MAR FAM PRACT	193.04	0	33.69
33. 70 33. 71	ELIMINATING ENTRIES	A	-198, 349		193. 12		33.70 33.71
33.71	PHYSICIAN RECRUITMENT ENTERTAINMENT EXP	A A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00		33.71
33.72	EMPLOYEE USE OF AUTO	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.72
33.74	DONATIONS	A		ADMINISTRATIVE & GENERAL	5.00	0	33.74
33.75	VHA OPPORTUNI TY	А	-119	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	33.75
33.76	VHA OPPORTUNI TY	А		ADMINISTRATIVE & GENERAL	5.00	0	33.76
33.77	VHA OPPORTUNI TY	A		OPERATION OF PLANT	7.00	0	33.77
33. 78 33. 79	VHA OPPORTUNI TY VHA OPPORTUNI TY	A		ADMI NI STRATI VE & GENERAL HOUSEKEEPI NG	5.00		33. 78 33. 79
33.80	VHA OPPORTUNI TY	A A		DI ETARY	10.00		33.80
33.81	VHA OPPORTUNI TY	A		NURSING ADMINISTRATION	13.00	0	33.81
33.82	VHA OPPORTUNI TY	А		CENTRAL SERVICES & SUPPLY	14.00	0	33.82
33.83	VHA OPPORTUNI TY	А	-31, 143	PHARMACY	15.00	0	33.83
33.84	VHA OPPORTUNI TY	А		ADULTS & PEDIATRICS	30.00	0	33.84
33.85	VHA OPPORTUNI TY	A		INTENSIVE CARE UNIT	31.00	0	33.85
33. 86 33. 87	VHA OPPORTUNI TY VHA OPPORTUNI TY	A		SUBPROVIDER - IRF	41.00 50.00	0	33.86
33.87	VHA OPPORTUNI TY	A A		OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	54.00		33.87 33.88
	VHA OPPORTUNI TY	A		CARDI AC CATHETERI ZATI ON	59.00		
33.90	VHA OPPORTUNI TY	А		LABORATORY	60.00		
33. 91	VHA OPPORTUNI TY	А	-614	ONCOLOGY	60. 01	0	33.91
33.92	VHA OPPORTUNI TY	А		RESPI RATORY THERAPY	65.00		
33.93	VHA OPPORTUNI TY	A		PHYSI CAL THERAPY	66.00		
33.94	VHA OPPORTUNI TY VHA OPPORTUNI TY	A		ELECTROCARDI OLOGY	69.00		33. 94 33. 95
33. 95 33. 96	VHA OPPORTUNITY VHA OPPORTUNITY	A A		CARDI AC REHAB	69.01 90.00	-	33.95
33.97	VHA OPPORTUNI TY	A		EMERGENCY	91.00		1
33.98	VHA OPPORTUNI TY	A		AMBULANCE SERVICES	95.00		
33.99	ED ON CALL SVC A/C 7000.2512	А	-1, 799, 341	ADMI NI STRATI VE & GENERAL	5.00		
34.00	MISC REV	В		LABORATORY	60.00		
34.01	RENT LAND OTHER-FARM LAND	В		ADMINISTRATIVE & GENERAL	5.00		
34.02 50.00	ELIMINATING ENTRIES TOTAL (sum of lines 1 thru 49)	A	-13, 209 -24, 737, 954	PACT REV PHYSICIANS	192.01	0	34.02 50.00
JU. UU	(Transfer to Worksheet A,		-24,131,734				30.00
	column 6, line 200.)						

 column 6, line 200.)

 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICLAN ADJUSTMENT Provider CCB: 15-0011 Portod: From 07/01/2021 To 06/30/2022 Worksheet A=-2 to 06/30/2022 Wisst: A Line # Cost Center/Physiclan Identifier Total Identifier Provider Remuneration Provider Component Provider Component RCE Amount Provider Component Wisst. A Line # Cost Center/Physiclan Identifier Total Remuneration Provider Component RCE Amount Provider Provider Remuneration RCE Amount Remuneration Provider Remuneration RCE Amount Remuneration	Heal th	Financial Syste	ems	MARI ON GENER	RAL HOSPI TAL		In Lie	eu of Form CMS-	2552-10
To 06/30/2021 Date/Time Propered: 11/30/2022 0.16 am Internit Fier Total Renumeration Professional Component Provider Component RCE Anount Physic i an /Provider Med Component 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 2.00 50.000/FERATING ROOM 3.683.192 0.00 0.00 2.00 3.00 4.00 5.00 0.00 2.00 3.00 4.00 5.00 0.00 2.00 3.00 3.03.192 0.00 0.00 2.00 3.00 3.03.192 0.00 0.0	PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (CCN: 15-0011			3-2
Wikst. A. Li ne # Cost Center/Physici an Identi Fi er Total Remuneration Professional Component RCE Amount Provider Component RCE Amount Provider Component Provider Ider Cemponent Hours 1.00 4.00 5.00 6.00 7.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 3.00 54.00RADI Loc CATHETE IXTION 50.00 CHERATI KK ROBIN 5.00 121.006 121.006 0							To 06/30/2022	2 Date/Time Pre	epared:
I denti Fi er Remunerati on Component Component I der Component 1.00 2.00 3.00 4.00 5.00 6.00 7.00 2.00 5.00 6.00 7.00 1.00 2.00 5.00 6.00 7.00 2.00 5.0000PERATINE ROM 3.683,192 3.683,192 0.600 0.00 0.00 2.00 3.00 5.00 6.00 0.00								11/30/2022 9:	<u>15 am</u>
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1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 50.000PERATING ROM 3.683.192 0 0 0 2.00 3.00 54.00[RADI OLGY-1] AGNOSTI C. 121.006 121.006 0 0 0 2.00 3.603.192 0 0 0 3.00 4.00 59.00[ARDI AC CATHETERI ZATI ON 121.078 121.078 0 0 4.00 5.00 0 4.00 5.00 0 4.00 5.00 0 0 4.00 5.00 0<			I denti fi er	Remuneration	Component	Component			
1.00 41.00 UBPROVIDER - IRF 17.775 17.775 0 <		1.00	0.00	0.00	4.00	F 00	(00		
2.00 50.000/DEPEATING ROOM 3,683,192 0 0 0 2.00 3.00 54.007ARDIAC CATHETERIZITION 121.006 121.006 0	1 00								1 00
3.00 54.00 RADI 0L0CY-DI AGNOSTI C 121.006 0 0 0 3.00 5.00 60.00 LABORATORY 121.078 121.078 0 0 0 4.00 5.00 60.00 LABORATORY 11.026 11.026 0 0 0 5.00 0 0 5.3.655 0							-	-	
4.00 59.00 CARDIAC CATHETERIZATION 121.078 121.078 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>								-	
5.00 60.00 (AB0RATORY 11.026 11.026 11.026 0 <								0	0.00
6.00 69.00 ELECTROCARDIOLOGY 53.655 53.655 4.859,819 0							°	0	
7. 00 91. 00 EMERGENCY 4, 859, 819 4, 859, 819 0								0	
8.00 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td></t<>								0	
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10.00 0.00 8,867,551 0 0 0 0 0 200.00 200.00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Cost of Memberships & Continuing Provider Component Share of col. Provider Component Provider Component Provider Component Provider Share of col. Provider I al practice I nsurance Provider Of Mal practice I nsurance Provider Component Provider Share of col. Provider Component Provider Share of col. Provider Component Provider Share of col. Provider Continuing Provider Continuing Provider Continuing Provider Continuing Provider Continuing Cost of Continuing Provider Continuing Provider Continuing Cost of Continuing Provider Continuing Cost of Continuing Provider Continuing Cost of Continuing Provider Continuing Cost of Continuing Cost of Continuing Cost of Continuing Cost of Continuing Cost O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0			0	
200.00				0	0			0	
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Identifier Limit Unadjusted RCE Limit Remberships & Continuing Education Component Share of col. 12 of Malpractice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 41.00 SUBPROVIDER - IRF 0 <t< td=""><td>200.00</td><td>Wkst Aline #</td><td>Cost Center/Physician</td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>	200.00	Wkst Aline #	Cost Center/Physician					-	
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1.00 41.00 SUBPROVIDER - IRF 0 <td></td> <td>1.00</td> <td>2.00</td> <td>8,00</td> <td>9,00</td> <td></td> <td></td> <td>14.00</td> <td></td>		1.00	2.00	8,00	9,00			14.00	
2.00 50.00 DPERATING ROOM 0 0 0 0 2.00 3.00 54.00RADI OLOGY-DI AGNOSTI C 0	1.00	41.00		0	0				1.00
4.00 59.00 CARDIAC CATHETERIZATION 0 <th< td=""><td>2.00</td><td>50.00</td><td>OPERATING ROOM</td><td>0</td><td>0</td><td></td><td></td><td>0</td><td>2.00</td></th<>	2.00	50.00	OPERATING ROOM	0	0			0	2.00
5.00 60.00 LABORATORY 0	3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(0 0	0	3.00
6.00 69.00 ELECTROCARDIOLOGY 0 <td>4.00</td> <td>59.00</td> <td>CARDIAC CATHETERIZATION</td> <td>0</td> <td>0</td> <td>(</td> <td>0 0</td> <td>0</td> <td>4.00</td>	4.00	59.00	CARDIAC CATHETERIZATION	0	0	(0 0	0	4.00
7.00 91.00 EMERGENCY 0	5.00	60.00	LABORATORY	0	0	(0 0	0	5.00
8.00 0.00 0.00 0	6.00	69.00	ELECTROCARDI OLOGY	0	0	(0 0	0	6.00
9.00 0.00 <th< td=""><td>7.00</td><td>91.00</td><td>EMERGENCY</td><td>0</td><td>0</td><td>(</td><td>0 0</td><td>0</td><td>7.00</td></th<>	7.00	91.00	EMERGENCY	0	0	(0 0	0	7.00
10.00 0.00 0<	8.00	0.00		0	0	(0 0	0	8.00
200.00 0 0 0 0 0 0 0 0 0 200.00 Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Limit RCE Disal Iowance Adjustment Adjustment Adjustment 1.00 2.00 15.00 16.00 17.00 18.00 100 1.00 2.00 1.00 2.00 1.00 1.00 1.00 2.00 16.00 17.00 18.00 1.00 2.00 50.00 OPERATING ROOM 0 0 0 3.683,192 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 121,006 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 11,026 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 5.00 6.00 4,859,819 7.00 8.00 0.00 0 0 0 0 0 9.0	9.00	0.00		0	0	(0 0	0	9.00
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Limit RCE Disal Iowance Adjustment 1.00 2.00 15.00 16.00 17.00 18.00 1.00 41.00 SUBPROVI DER - I RF 0 0 0 17,775 1.00 2.00 50.00 OPERATI NG ROOM 0 0 0 121,006 3.00 3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 11,026 5.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 11,026 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 0 0 8.00 0 0 0 8.00 0.00 0 0 0 0 0 0 9.00 0 9.00 0.00 0 0 0 0 0 0 9.00 10.00 <td>10.00</td> <td>0.00</td> <td></td> <td>0</td> <td>0</td> <td>(</td> <td>0 0</td> <td>0</td> <td>10.00</td>	10.00	0.00		0	0	(0 0	0	10.00
Identifier Component Share of col. 14 Limit Disal I owance Imit Disal I owance 1.00 2.00 14 1 0 18.00 0 100 <td< td=""><td>200.00</td><td></td><td></td><td>0</td><td>0</td><td>(</td><td>0 0</td><td>0</td><td>200.00</td></td<>	200.00			0	0	(0 0	0	200.00
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1.00 41.00 SUBPROVIDER - IRF 0 0 17,775 1.00 2.00 50.00 OPERATING ROOM 0 0 0 3,683,192 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTIC 0 0 0 121,006 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 11,026 5.00 6.00 60.00 LABORATORY 0 0 0 11,026 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 3.00 8.00 9.00 0 0 8.00 9.00 0 9.00 9.00 0 9.00								-	
2.00 50.00 OPERATING ROOM 0 0 3,683,192 2.00 3.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0 121,006 3.00 4.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 121,078 4.00 5.00 60.00 LABORATORY 0 0 0 11,026 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 4,859,819 7.00 8.00 0.00 0 0 0 0 9.00 0 9.00 0 9.00 10.00 9.00 10.00 0.00 0 0 0 0 0 9.00 10.00	1.00								1.00
3. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 121, 006 3. 00 4. 00 59. 00 CARDI AC_CATHETERI ZATI ON 0 0 0 121, 078 4. 00 5. 00 60. 00 LABORATORY 0 0 0 11, 026 5. 00 6. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 53, 655 6. 00 7. 00 91. 00 EMERGENCY 0 0 0 4, 859, 819 7. 00 8. 00 0.00 0 0 0 0 9. 00 9. 00 10. 00 9. 00 10. 00 10. 00 9. 00 9. 00 10. 00 9. 00 10. 00 9. 00 9. 00 10.				0	-				
4.00 59.00 CARDIAC CATHETERIZATION 0 0 121,078 4.00 5.00 60.00 LABORATORY 0 0 0 11,026 5.00 6.00 69.00 ELECTROCARDIOLOGY 0 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 4,859,819 7.00 8.00 0.00 0 0 0 0 8.00 9.00 10.00 10.00 10.00 0.00 0 0 0 0 9.00 10.00				0					
5.00 60.00 LABORATORY 0 0 11,026 5.00 6.00 69.00 ELECTROCARDI OLOGY 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 4,859,819 7.00 8.00 0.00 0 0 0 0 9.00 9.00 9.00 10.00 0.00 0 0 0 0 9.00 10.00				0					
6.00 69.00 ELECTROCARDIOLOGY 0 0 53,655 6.00 7.00 91.00 EMERGENCY 0 0 0 4,859,819 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0 9.00 9.00 0 9.00 10.00 10.00 9.00 10.00				0	-				
7.00 91.00 EMERGENCY 0 0 4,859,819 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 9.00 10.00 9.00 10.00 <td< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>				0					
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Heal th	Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 07/01/2021	Worksheet B Part I	
					0 06/30/2022	Date/Time Pre	
	· · · · · · · · · · · · · · · · · · ·		CAPI TAL			11/30/2022 9:	
		Not Fundament	RELATED COSTS		Cultated		
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	EMPLOYEE BENEFI TS	Subtotal	ADMI NI STRATI V E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		<u>col.7)</u>	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS			ľ	ľ	Ĺ	
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	10, 866, 171 16, 571, 595		16, 835, 022			1.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	23, 777, 390		2, 757, 011		29, 890, 781	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	
6. 01 6. 02	00601 CAFETERI A 00602 CAFETERI A	1, 647, 897	118, 097	0	1, 765, 994	360, 672	6.01 6.02
7.00	00700 OPERATION OF PLANT	6, 149, 401	2, 181, 385	184, 833	8, 515, 619	1, 739, 162	•
8.00	00800 LAUNDRY & LINEN SERVICE	374, 372		0	425, 749	86, 952	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 711, 914 684, 341			_, ,		1
	01300 NURSI NG ADMI NI STRATI ON	1, 216, 248				298, 964	•
	01400 CENTRAL SERVICES & SUPPLY	569, 351				135, 519	
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	3, 823, 826	74,647	545,072	4, 443, 545	907, 514	15.00
	03000 ADULTS & PEDIATRICS	10, 567, 236	1, 028, 373			2, 709, 197	30.00
	03100 I NTENSI VE CARE UNI T	4, 528, 823	265, 616	543, 958	5, 338, 397	1, 090, 271	31.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	2,057,614	Ŭ	265, 347	2, 556, 019	0 522, 021	40.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	1, 732, 409	0	297, 253	2, 029, 662	414, 522	43.00
50.00	05000 OPERATING ROOM	8, 540, 397	837, 720	691, 098	10, 069, 215	2, 056, 456	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	4, 593, 543 910, 074		551, 316 108, 828		1, 153, 469 215, 566	•
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	494, 875				121, 698	
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 341, 119		172, 482			•
60. 00 60. 01	06000 LABORATORY 06001 ONCOLOGY	8, 869, 767 1, 615, 451		466, 838 204, 321	9, 690, 921 1, 819, 772	1, 979, 196 371, 656	•
	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 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 964, 894 2, 284, 827		355, 708 398, 739		711, 454 582, 816	
	06900 ELECTROCARDI OLOGY	1, 133, 283		206, 620		313, 150	
	06901 CARDI AC REHAB	228, 600	31, 512	36, 404		60, 558	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	-	0	
	07300 DRUGS CHARGED TO PATIENTS	11, 891, 348			-		•
00.00	OUTPATIENT SERVICE COST CENTERS	939, 489	110 021	E2 140	1 111 470	227, 040	90.00
	09000 CLINIC 09100 EMERGENCY	7, 648, 607					90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92.01
	09500 AMBULANCE SERVICES	1, 565, 774	100, 907	259, 153	1, 925, 834	393, 317	95.00
	SPECIAL PURPOSE COST CENTERS	1	1				
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	143, 300, 636	10, 833, 857	11, 978, 203	138, 411, 503	22, 163, 333	113.00 118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	32, 591 0		4, 596 0	69, 501 0		190. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES	758, 436	-	129, 067	887, 503	181, 257	
192.02	19202 VISITOR MEALS	0	0	0	0	0	192.02
	19203 GREAT BEGI NNI NGS/MATERNAL 19204 LI FELI NE	16, 552	0	3, 272			192.03 192.04
	19205 OWNED PROPERTIES	543, 523	0	0	543, 523	111, 005	
192.06	19206 UROLOGY	1, 428, 842	0	201, 433	1, 630, 275	332, 954	192.06
	19207 PHYSI CLANS' PRI VATE OFFI CES 19211 PARI SH NURSI NG	0 69, 762	0	0 11, 955	0 81, 717		192. 07 192. 08
	19212 BI OTERRORI SM GRANT	07,702	0	0	01,717		192.00
192.10	19214 BREAST PUMPS	0	0	0	0	0	192.10
	19208 MGH EMERGENCY PHYSICIANS 19209 LUNG CENTER	0 780, 606	0	0 138, 452	0 919, 058	0 187, 701	192.11 192.12
	19209 LONG CENTER 19213 MGH EXPRESS	1, 638, 034		248, 281	1, 886, 315	385, 246	
192.14	19210 MGH PHYS PRACT MGMT	2, 871, 485	0	310, 861	3, 182, 346	649, 937	192.14
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	2, 105, 888 1, 471, 449		374, 012 269, 463		506, 475 355, 550	•
	19217 MGH FMC SOUTH	1, 914, 849					

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
				rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre	nared
				0 00/ 30/ 2022	11/30/2022 9:	
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost Allocation	FI XT	BENEFI TS DEPARTMENT		E & GENERAL	
	(from Wkst A		DEPARTMENT			
	col. 7)					
	0	1.00	4.00	4A	5.00	
192. 18 19218 MGH FAIRM MED ASSOC	347, 140	0	51, 319	398, 459		192.18
192.19 19219 MGH FMC MARION	1, 437, 867	0	233, 808	1, 671, 675	341, 410	192.19
193. 00 19300 NONPAI D WORKERS	0	0	0	0		193.00
193.01 19301 MGH FMC NORTHWOOD	1, 215, 710	0	199, 413	1, 415, 123		•
193.02 19302 MGH FMC GAS CITY	939, 706	0	129, 065	1, 068, 771	218, 277	•
193. 03 19303 MGH HOSPI TALI STS	3, 578, 427	0	653, 629	4, 232, 056		
193. 04 19304 MGH MAR FAM PRACT	3, 588, 247	0	578, 643	4, 166, 890		
193.05 19305 MGH FMC SWAYZEE 193.06 19306 MGH PEDIATRIC CTR	245, 153 884, 462	0	38, 161 133, 769	283, 314 1, 018, 231	57, 862 207, 955	
193. 07 19307 MGH SPECIALTY PHYS	311, 315	0	51, 562	362, 877	74, 111	
193. 08 19308 MGH FMC CONVERSE	379, 878	0	50, 536			193.08
193. 09 19309 MGH UPLAND HEALTH	0	0	00,000	0		193.09
193. 10 19310 MGH MGH WOMENS CTR	0	0	0	0		193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0	0	0	0	193.11
193. 12 19312 OB/GYN	2, 578, 590	0	392, 133	2, 970, 723	606, 717	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0		193. 15
193.16 19316 MGH NEONATOLOGY	888, 000	0	0	888, 000		
193.18 19318 MGH WOUND CARE	26, 634	0	4, 890	31, 524		193. 18
194.00 07963 HEART FAILURE CLINIC	55, 287	0	7, 397	62, 684		194.00
194. 01 07950 MOW	0	0	0	0		194.01
194. 02 07951 MENTAL_HEALTH 194. 03 07952 ADVERTI SI NG	145, 569	0	0 27, 031	0 172, 600		194.02 194.03
194. 04 07953 MGH WORK SOLUTIONS	720, 485	0	81, 153	801, 638		
194. 05 07954 MGH TAYLOR UNIVERSITY	/20,403	0	01, 133	001,030		194.05
194. 06 07955 OPI OI D I MPL GRANT	441, 720	0	8, 696	450, 416		
194. 07 07956 ASTHMA GRANT	0	0	0	0		194.07
194.0807957 MGH SMMP BLDG	0	0	0	0	0	194.08
194.0907958 MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.1007959MGH 106 LYONS BLDG	0	0	0	0		194.10
194. 11 07960 FAI RMOUNT	0	0	0	0		194.11
194. 12 07961 GAS CI TY	0	0	0	0		194.12
194. 13 07969 LYONS	0	0	0	0		194.13
194. 14 07964 WABASH 194. 15 07965 TOBACCO GRANT	65, 345	0	7,077	0 72, 422		194. 14 194. 15
194. 16 07966 HRSA NETWORK DEV PLANNING	05, 345	0	, , , , , , , , , , , , , , , , , , ,	72,422		194.15
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0	0	0		194.10
194. 18 07962 ECHO GRANT	27,939	0	392	28, 331		194.18
194. 19 07968 RURAL QI GRANT	75, 140	0	5, 165	80, 305		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		194.22
194. 23 07973 DI ABETES GRANT	8, 779	0	0	8, 779		194.23
194. 24 07974 HEALTH SYS GRANT	0	0	0	0		194.24
194. 25 07975 MGH MGH ORTHO	1, 354, 081	0	242, 334	1, 596, 415	326, 039	
200.00 Cross Foot Adjustments			_	0	_	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	176, 248, 127	0 10, 866, 171	0 16, 835, 022	0 176, 248, 127		201.00
202.00 TOTAL (Sum TIMES TTO THE OUGH 201)	170, 240, 127	10,000,171	10, 035, 022	170, 240, 127	27,070,701	202.00

	Financial Systems	MARION GENERA				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 07/01/2021	Worksheet B Part I	
				T	0 06/30/2022	Date/Time Pre 11/30/2022 9:	epared: 15 am
	Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
		REPAIRS 6.00	6. 01	6.02	PLANT 7.00	LINEN SERVICE 8.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS	0					6.00
6.01	00601 CAFETERI A	0	2, 126, 666				6.01
6.02 7.00	00602 CAFETERIA 00700 OPERATION OF PLANT	0	2, 104, 543	2, 104, 543 66, 951	10, 321, 732		6.02
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	00, 751	107, 199	619, 900	
9.00	00900 HOUSEKEEPI NG	0	0	0	165, 390	0	
10.00 13.00	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON	0	0	563 35, 581	339, 507 35, 310	73, 434 0	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	15, 054	120, 897	10	
15.00	01500 PHARMACY	0	0	104, 350	155, 751	0	15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	o	241 421	2 145 715	131, 385	30.00
30.00	03100 INTENSIVE CARE UNIT	0	0	341, 421 87, 154	2, 145, 715 554, 210	33, 374	
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	
41.00	04100 SUBPROVI DER - I RF	0	0	56, 034	486, 278	13, 979	
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0	0 59, 872	0	0	
10.00	ANCI LLARY SERVICE COST CENTERS			07,072			10.00
50.00	05000 OPERATING ROOM	0	0	172, 713		54, 185	
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	0	0 150, 514	0 1, 049, 468	0 34, 895	
57.00	05700 CT SCAN	0	0	30, 894	76, 354	20, 640	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	16, 359	90, 508	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	41, 744	255, 696	6, 520	
60.00 60.01	06000 LABORATORY 06001 ONCOLOGY	0	0	135, 109 0	739, 285 0	0 1, 936	
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	65, 583 41, 803	340, 014 354, 981	5, 172 12, 529	
69.00	06900 ELECTROCARDI OLOGY	0	0	64, 140	403, 532	4, 120	
69.01	06901 CARDI AC REHAB	0	0	9, 075	65, 750	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS		-				
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0	0	17, 240 208, 619	248, 339 561, 668	1, 180 207, 176	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ŭ	0	200,017	301,000	207, 170	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	88, 559	210, 543	17, 760	05.00
7 5.00	SPECIAL PURPOSE COST CENTERS	0	0	00, 339	210, 343	17,700	95.00
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	2, 104, 543	1, 809, 332	10, 254, 308	618, 295	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1, 309	67, 424	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19201 PACT REV PHYSICIANS 19202 VISITOR MEALS	0	0	5, 109	0		192.01 192.02
	19202 VESTOR MEALS 19203 GREAT BEGENNENGS/MATERNAL	0	22, 123 0	0	0		192.02
	19204 LI FELI NE	0	0	0	0		192.04
	19205 OWNED PROPERTIES	0	0	0	0		192.05
	19206 UROLOGY 19207 PHYSI CLANS' PRI VATE OFFI CES	0	0	31, 378 0	0		192.06 192.07
	19211 PARI SH NURSI NG	0	0	3, 270	0		192.08
	19212 BI OTERRORI SM GRANT	0	0	0	0		192.09
	19214 BREAST PUMPS 19208 MGH EMERGENCY PHYSICIANS	0	0	0	0		192.10 192.11
	19209 LUNG CENTER	0	0	11, 223	0		192.12
192.13	19213 MGH EXPRESS	0	0	0	0	712	192.13
	19210 MGH PHYS PRACT MGMT	0	0	112, 970	0		192.14
	19215 MGH MARION SURGEONS 19216 MGH MGH MED ONC	0		39, 482 0	0		192.15 192.16
	19217 MGH FMC SOUTH	0	0	0	0	56	192.17
	19218 MGH FAIRM MED ASSOC	0	0	0	0	17	192.18
192.18		-	1	4 4 0	_		100
192.18 192.19	19219 MGH FMC MARION	0	0	44, 275 0	0	63	192.19
192. 18 192. 19 193. 00 193. 01		0000	0 0 0	44, 275 0 0 0	0 0 0 0	63 0 0	192. 19 193. 00 193. 01 193. 02

Health Financial Systems	MARI ON GENERAL				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B	
				From 07/01/2021 To 06/30/2022		nared
				10 00/30/2022	11/30/2022 9:	
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	464	193.04
193.05 19305 MGH FMC SWAYZEE	0	0		0 0	0	193.05
193. 06 19306 MGH PEDIATRIC CTR	0	0	21, 35			193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	6, 98	1 0	0	193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 0		193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 0		193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0		193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0 0		193.11
193. 12 19312 OB/GYN	0	0		0 0		193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 0		193.15
193.16 19316 MGH NEONATOLOGY	0	0		0 0		193.16
193.18 19318 MGH WOUND CARE	0	0		0 0		193.18
194.00 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	7,45			194.03
194. 04 07953 MGH WORK SOLUTIONS	0	0		0 0		194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0 0		194.05
194. 06 07955 OPI OLD IMPL GRANT	0	0		0 0		194.06
194. 07/07956 ASTHMA GRANT	0	0		0 0		194.07 194.08
194.08 07957 MGH_SMMPBLDG 194.09 07958 MGH_AMBUCARE_BLDG	0	0				194.08
194. 10/07959 MGH 106 LYONS BLDG	0	0		0 0		194.09
194. 10/07959 MGH 108 LYONS BEDG 194. 11/07960 FAI RMOUNT	0	0		0 0		194.10
194. 12 07961 GAS_CITY	0	0				194.11
194. 12 07981 GAS CTTT 194. 13 07969 LYONS	0	0				194.12
194. 14 07964 WABASH	0	0				194.13
194. 15 07965 TOBACCO GRANT	0	0	2, 58	0		194.14
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0				194.16
194. 17 07967 HRSA OPI OLD PLANNING	0	0		0 0		194.17
194. 18 07962 ECHO GRANT	0	0	16	0		194.18
194. 19 07968 RURAL QI GRANT	0	0	2, 55			194.19
194. 20 07970 MGH DI ABETES GRANT	0	0	4,49			194.20
194. 21 07971 MGH MGH ORTHO	0	0		0 0		194.21
194. 22 07972 MGH BELLA BLDG	0	0		0 0		194.22
194. 23 07973 DI ABETES GRANT	0	0		0 0		194.23
194. 24 07974 HEALTH SYS GRANT	0	0	60	-		194.24
194. 25 07975 MGH MGH ORTHO	0	0		0 0		194.25
200.00 Cross Foot Adjustments		-				200.00
201.00 Negative Cost Centers	0	0		o o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	2, 126, 666	2, 104, 54	3 10, 321, 732	619, 900	202.00
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Health Financial Systems	MARI ON GENERAI	L HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: .om 07/01/2021	Worksheet B Part I	
			To		Date/Time Pre	
Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG	CENTRAL	11/30/2022 9: PHARMACY	15 am
			ADMI NI STRATI O	SERVICES &		
	9.00	10.00	N 13.00	SUPPLY 14.00	15.00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMI NI 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 10. 00 01000 DI ETARY	3, 526, 618 50, 516	1, 489, 072				9.00 10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	15, 786	1,407,072	1, 849, 485			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	78, 931	0	21, 152	1, 035, 115		14.00
15.00 01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	44, 201	0	0	0	5, 655, 361	15.00
30. 00 03000 ADULTS & PEDIATRICS	934, 539	807, 908	479, 711	112, 735	0	30.00
31.00 03100 I NTENSI VE CARE UNI T	176, 804	150, 640	122, 455	51, 243	0	31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0 151, 547	0 127, 395	0 78, 730	0 10, 249	0	40.00
42. 00 04200 SUBPROVI DER	0	0	0	10, 249	0	42.00
43.00 04300 NURSERY	0	0	84, 122	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	467, 269	0	242, 668	215, 220	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	200, 484	0	0	10, 249	0	54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 050	0	0	0	0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	63, 144	0	58, 651	61, 492	0	59.00
60. 00 06000 LABORATORY	176, 804	0	0	61, 492	0	60.00
60. 01 06001 0NCOLOGY 60. 02 06002 RADI ATI ON ONCOLOGY	0	0	0	10, 249 0	0	60.01 60.02
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	132, 603	0	98, 502	20, 497	0	65.00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0 85, 245	0	58, 735 90, 119	0 30, 746	0	66.00 69.00
69. 01 06901 CARDI AC REHAB	94, 717	0	12, 751	00, 710	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	0	0 5, 655, 361	72.00 73.00
OUTPATIENT SERVICE COST CENTERS		-	-1		-,	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	63, 144	0	24, 223	0 E1 242	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	707, 218	56, 058	293, 117	51, 243	0	91.00 92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	22, 101	0	124, 428	0	0	95.00
SPECIAL PURPOSE COST CENTERS	22, 101	0	124, 420	U	0	95.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	3, 476, 103	1, 142, 001	1, 789, 364	635, 415	5, 655, 361	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 314	0	0	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
192. 01 19201 PACT REV PHYSICIANS 192. 02 19202 VISITOR MEALS	0	0	0	0		192. 01 192. 02
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	0	0	1, 000	0		192.03
192. 04 19204 LI FELI NE	0	0	0	0		192.04
192. 05 19205 OWNED PROPERTIES 192. 06 19206 UROLOGY	0	0	0	40, 995		192.05 192.06
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES	12, 629	0	0	0	0	192.07
192. 08 19211 PARI SH NURSI NG	6, 314	0	0	0		192.08
192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS	0	0	0	0		192. 09 192. 10
192. 11 19208 MGH EMERGENCY PHYSI CLANS	0	0	0	0	0	192. 11
192. 12 19209 LUNG CENTER	0	0	0	0		192.12
192.13 19213 MGH EXPRESS 192.14 19210 MGH PHYS PRACT MGMT	0 25, 258	0	59, 121 0	20, 497 0		192. 13 192. 14
192.15 19215 MGH MARION SURGEONS	0	0	0	30, 746	0	192. 15
192.16 19216 MGH MGH MED ONC	0	0	0	0		192.16
192. 17 19217 MGH FMC SOUTH 192. 18 19218 MGH FAI RM MED ASSOC	0	0	0	30, 746 0		192. 17 192. 18
192.19 19219 MGH FMC MARION	0	0	0	30, 746	0	192.19
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
193.01 19301 MGH FMC NORTHWOOD	0	0	0	10, 249	0	193.01

Health Financial Systems	MARION GENERAL				u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prepared: 11/30/2022 9:15 am
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY
			ADMI NI STRATI		
			N	SUPPLY	
	9.00	10.00	13.00	14.00	15.00
193.02 19302 MGH FMC GAS CITY	0	0		0 10, 249	0 193.02
193. 03 19303 MGH HOSPI TALI STS	0	0	1	0 0	0 193.03
193.04 19304 MGH MAR FAM PRACT	0	0		0 61, 492	0 193.04
193.05 19305 MGH FMC SWAYZEE	0	0		0 10, 249	0 193.05
193. 06 19306 MGH PEDI ATRI C CTR	0	0		0 10, 249	0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	0 193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 10, 249	0 193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 0	0 193.09
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		0 102, 487	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	233, 084		0 0	0 194.01
194.0207951 MENTAL HEALTH	0	113, 987		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 20, 497	0 194.04
194.0507954 MGH TAYLOR UNIVERSITY	0	0		0 0	0 194. 05
194.06079550PIOID IMPL GRANT	0	0		0 0	0 194.06
194.0707956ASTHMA GRANT	0	0		0 0	0 194.07
194.08 07957 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 10, 249	0 194. 12
194. 13 07969 LYONS	0	0		0 0	0 194. 13
194. 14 07964 WABASH	0	0		0 0	0 194. 14
194. 15 07965 TOBACCO GRANT	0	0		0 0	0 194. 15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0		0 0	0 194. 16
194. 17 07967 HRSA OPI OI D PLANNI NG	0	0		0 0	0 194. 17
194. 18 07962 ECHO GRANT	0	0		0 0	0 194. 18
194. 19 07968 RURAL QI GRANT	0	0		0 0	0 194. 19
194. 20 07970 MGH DI ABETES GRANT	0	0		0 0	0 194.20
194. 21 07971 MGH MGH ORTHO	0	0		0 0	0 194.21
194. 22 07972 MGH BELLA BLDG	0	0		0 0	0 194. 22
194. 23 07973 DI ABETES GRANT	0	0		0 0	0 194.23
194. 24 07974 HEALTH SYS GRANT	0	0		0 0	0 194. 24
194. 25 07975 MGH MGH ORTHO	0	0		0	0 194. 25
200.00 Cross Foot Adjustments		~			200.00
201.00 Negative Cost Centers		1 400 070	1 040 4		0 201.00
202.00 TOTAL (sum lines 118 through 201)	3, 526, 618	1, 489, 072	1, 849, 4	85 1, 035, 115	5, 655, 361 202. 00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	MARION GENERA	AL HOSPITAL Provider CC	N· 15_0011	In Lieu of Form Period: Workshee	
CUST ALLOCATION - GENERAL SERVICE CUSIS		FI OVI def: CC	N. 10-0011	From 07/01/2021 Part I	
	_			To 06/30/2022 Date/Time 11/30/202	e Prepared: <u>22 9:15 am</u>
Cost Center Description	Subtotal	Intern & Residents	Total		
		Cost & Post			
		Stepdown Adjustments			
	24.00	25.00	26.00	_	
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					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					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					14.00 15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	20, 928, 256	0	20, 928, 25		30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	7, 604, 548	0	7, 604, 54	0	31.00 40.00
41.00 04100 SUBPROVIDER - IRF	4, 002, 252	0	4,002,25	52	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0	0 E00 1	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	2, 588, 178	U	2, 588, 17	Ø	43.00
50. 00 05000 OPERATI NG ROOM	15, 025, 639	0	15, 025, 63		50.00
51. 00 05100 RECOVERY ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 8, 246, 915	0	8, 246, 91	0	51.00 54.00
57. 00 05700 CT SCAN	1, 410, 000	0	1, 410, 00		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	824, 445	0	824, 44	15	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	3, 661, 781 12, 782, 807	0	3, 661, 78 12, 782, 80		59.00 60.00
60. 01 06001 ONCOLOGY	2, 203, 613	0	2, 203, 61		60.00
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0	60.02
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	4, 857, 385	0	4, 857, 38	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	3, 904, 561	0	3, 904, 56		66.00
69. 00 06900 ELECTROCARDI OLOGY	2, 524, 355	0	2, 524, 35		69.00
69. 01 06901 CARDIAC REHAB 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	539, 367	0	539, 36	0	69.01 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	19, 975, 303	0	19, 975, 30	03	73.00
90. 00 09000 CLINIC	1, 692, 844	0	1, 692, 84	14	90.00
91.00 09100 EMERGENCY	13, 885, 494	0	13, 885, 49		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	92.00 92.01
OTHER REIMBURSABLE COST CENTERS	0	0			92.01
95. 00 09500 AMBULANCE SERVICES	2, 782, 542	0	2, 782, 54	2	95.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)) 129, 440, 285	0	129, 440, 28	35	118.00
NONREI MBURSABLE COST CENTERS	150 740		150 7	10	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	158, 742	0	158, 74	0	190.00 192.00
192. 01 19201 PACT REV PHYSICIANS	1, 073, 869	0	1, 073, 86	.9 9	192.01
192. 02 19202 VI SI TOR MEALS	22, 123	0	22, 12		192.02
192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 192. 04 19204 LI FELI NE	24, 873	0	24, 87	0	192.03 192.04
192.05 19205 OWNED PROPERTIES	654, 528	0	654, 52		192.05
192. 06 19206 UROLOGY	2,035,602	0	2,035,60		192.06 192.07
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19211 PARI SH NURSI NG	12, 629 107, 990	0	12, 62 107, 99		192.07
192. 09 19212 BI OTERRORI SM GRANT	0	0		0	192.09
192. 10 19214 BREAST PUMPS 192. 11 19208 MGH EMERGENCY PHYSICIANS	0	0		0	192. 10 192. 11
192. 11 19208 MGH EMERGENCY PHYSICIANS 192. 12 19209 LUNG CENTER	1, 117, 982	0	1, 117, 98	32	192.11
192. 13 19213 MGH EXPRESS	2, 351, 891	0	2, 351, 89	21	192.13
192.14 19210 MGH PHYS PRACT MGMT 192.15 19215 MGH MARION SURGEONS	3, 970, 511	0	3, 970, 51 3, 056, 73		192. 14 192. 15
192. 16 19215 MGH MARION SURGEONS 192. 16 19216 MGH MGH MED ONC	3, 056, 727 2, 096, 462	0	3, 056, 72 2, 096, 46		192.15
192.17 19217 MGH FMC SOUTH	2, 660, 969		2, 660, 96	99	192.17
192. 18 19218 MGH FAI RM MED ASSOC	479, 854		479,85		192.18
192. 19 19219 MGH FMC MARI ON	2, 088, 169	l Ol	2, 088, 16	⁷⁷	192.19

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0011	Period: Worksheet B From 07/01/2021 Part I To 06/30/2022 Date/Time Prepared: 11/30/2022 9:15 am
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
193.00 19300 NONPAI D WORKERS	0	0		0 193.00
193.01 19301 MGH FMC NORTHWOOD	1, 714, 385	0	1, 714, 38	
193. 02 19302 MGH FMC GAS CITY	1, 297, 407	0	1, 297, 40	
193. 03 19303 MGH HOSPITALISTS	5,096,377	0	5,096,3	
193.04 19304 MGH MAR FAM PRACT 193.05 19305 MGH FMC SWAYZEE	5, 079, 858 351, 425	0	5, 079, 85 351, 42	
193. 06 19306 MGH PEDIATRIC CTR	1, 257, 813	0	1, 257, 8	
193. 07 19307 MGH SPECIALTY PHYS	443, 969	0	443, 90	
193. 08 19308 MGH FMC CONVERSE	528, 581	0	528, 58	
193.09 19309 MGH UPLAND HEALTH	0	0		0 193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 193.10
193.11 19311 MGH MGH PSYCHLATRY	0	0		0 193.11
193. 12 19312 OB/GYN	3, 679, 927	0	3, 679, 92	
193.15 19315 MGH RIVER VIEW BLDG	0	0		0 193.15
193. 16 19316 MGH NEONATOLOGY	1,069,358	0	1,069,3	
193. 18 19318 MGH WOUND CARE	37, 962	0	37,90	
194. 00 07963 HEART_FALLURE_CLINIC 194. 01 07950 MOW	75, 486	0	75, 48	
194.02 07951 MENTAL HEALTH	233, 084 113, 987	0	233, 08 113, 98	
194. 03 07952 ADVERTI SI NG	215, 302	0	215, 30	
194. 04 07953 MGH WORK SOLUTI ONS	985, 877	0	985, 8	
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0	,.	0 194.05
194.06079550PI0IDIMPL GRANT	542, 405	0	542, 40	194.06
194.0707956 ASTHMA GRANT	0	0		0 194.07
194.0807957 MGH SMMP BLDG	0	0		0 194.08
194.0907958MGH 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	10.0	0 194.11
194. 12 07961 GAS CI TY 194. 13 07969 LYONS	10, 249	0	10, 24	19 194. 12 0 194. 13
194. 14 07964 WABASH	0	0		0 194.13
194. 15 07965 TOBACCO GRANT	89, 796	0	89, 79	
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0	, -	0 194.16
194. 17 07967 HRSA OPI OLD PLANNI NG	0	0		0 194.17
194. 18 07962 ECHO GRANT	34, 286	0	34, 28	36 194. 18
194. 19 07968 RURAL QI GRANT	99, 257	0	99, 25	
194.2007970 MGH DI ABETES GRANT	4, 498	0	4,49	
194. 21 07971 MGH MGH ORTHO	0	0		0 194.21
194. 22 07972 MGH BELLA BLDG	10 572	0	10 5	0 194.22
194. 23 07973 DI ABETES GRANT 194. 24 07974 HEALTH SYS GRANT	10, 572 606	0	10, 5	72 194. 23 06 194. 24
194. 25 07975 MGH MGH ORTHO	1, 922, 454	0	60 1, 922, 4	
200.00 Cross Foot Adjustments	1, 922, 434	0	1, 722, 43	0 200.00
201.00 Negative Cost Centers	0	0		0 201.00
202.00 TOTAL (sum lines 118 through 201)	176, 248, 127	0	176, 248, 12	
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From 07/01/2021 Part II appropried To 66/30/2022 Part II appropried Th/30/2022 (9) is an Example of the propried Part Discover (1) approximate of the propried Discover (1) approximate of the propried Discover (1) approximate of the propried Discover (1) approximate of the propried Discover (1) approver (1) approximate of the proprover (1) approxim		Financial Systems	MARI ON GENER		01 45 0044 D		u of Form CMS-	2552-10
Cost Center Description EALED 03 (EALED 03) (EALED 03) (EAL	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	rom 07/01/2021		
Loss Conter Jescri pti on Braches Argin Laboratory (a) (a) Balance (a) (b) Balance (a)						0 06/30/2022		
Cost Center Description Directly Resident option NPB D0 A Fixit Directly Sublicities PBB D0 A Fixit Directly Sublicities 0 00100 LIG CVCCT CPRTRS 0 A 4 00 5.00 1 00100 LIG CVCCT CPRTRS 0 263, 427 263, 427 263, 427 263, 427 4.00 5.00 1 00100 LIG CVCCT CPRTRS 0 3, 255, 300 3, 356, 300 263, 427 263, 427 263, 427 4.100 6.00 0.000 CVCWINISTRATUV & GPREAL 0 110, 007 110, 007 0 4.100 6.00 0.000 CVCWINISTRATUV & GPREAL 0 110, 007 110, 007 0 4.101, 007 100 4.101, 007 100 4.101, 007 100, 00 4.111, 007 100, 00 4.111, 007 100, 00 4.111, 100 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00 100, 00<								
Control Control <t< td=""><td></td><td>Cost Center Description</td><td>Di rectl y</td><td></td><td></td><td>EMPLOYEE</td><td>ADMI NI STRATI V</td><td></td></t<>		Cost Center Description	Di rectl y			EMPLOYEE	ADMI NI STRATI V	
Internal Stand IC Cost S 0 4 0 5.00 IDENDIFY SERVICE COST CENTERS 0 2263, 427 2263, 427 2263, 427 2263, 427 1.00 0.0000 LARD VISE EDENTIS FLORE A FIXT 0 3.265, 380 3.56, 380 4.510 3.397, 641 5.00 0.0000 LARD VISE EDENTIS FLORE A FIXT 0 3.265, 380 4.510 3.397, 641 5.00 0.0000 LARD VISE EDENTIS FLORE A FIXT 0 1.80, 00 118, 00 0 6.00 7.00				FLXT			E & GENERAL	
OPERAL SIRVIC CONTOURING 0 1.00 2A 4.00 5.00 100 000000 000000 000000 000000 000000 000000 000000 000000 000000 0000000 000000 0000000 0000000 000000000000000000000000000000000000						DEPARTMENT		
1.00 DICOLONER CAP REL COSTS-BLOX & FIXT 0 2.03, 427 2.00, 427 7.00 </td <td></td> <td>F</td> <td></td> <td></td> <td>2A</td> <td>4.00</td> <td>5.00</td> <td></td>		F			2A	4.00	5.00	
4.00 DAND (PARD OFFE DEFINITING THE PARTING TO CONSTITUTING TO THE PARTING TO THE PART OF THE PART	1 00							1 1 00
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6.11 00001 CAFETERIA 0 118.097 118.097 0 0 1.0.00 6.00 0 0 0.00000 0.00000 0.0000			C	3, 356, 380	3, 356, 380			
6.02 00020 CALE TERIA A 0			0		0			
8.00 000000 LAMNERY & LINEN SERVICE 0 51.377 51.377 9.78.97 9.889 8.00 0.00 00000 LINEN CPU MINISTRATION 0 16.22,715 16.2,725 16.2,725 16.2,725 16.2,725 16.2,725 16.2,725 16.2,725 16.2,725 16.00 17.	6.02			0	0	0		1
9.00 00000 HOUSEXEERING 0 79, 260 79, 260 79, 260 0 64, 834 9.00 73, 200 01000 HUSEXEERING 0 16, 923 1	7.00		C			2, 892		
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13.00 01300 NURSING ADMINISTRATION 0 16, 62, 23 3, 009 34, 002 13, 00 15.00 DISOD FURMALS SERVICE OST CENTERS 0 74, 647 76, 60 76, 60 76, 60 76, 60 76, 60 76, 60 76, 60 76, 60 76, 60 76, 70 76, 72 86, 77, 720 867, 720 867, 720 867, 720 867, 720 867, 720 867, 720 867, 720 867, 720 867, 720 867, 720 867, 749 86, 71 86, 80 96, 00 760, 765, 7647 76, 742 76, 744 <						-		
Insol DISOD PHARMACY 0 74, 647 74, 647 8, 528 103, 215 15. 00 INVART IR DUTI IN SPERVICE COST CENTERS 0 1,028, 373 1,028, 373 22,129 308, 09 30. 00 3000 ADULTS & PEDIATRICS 0 </td <td>13.00</td> <td></td> <td>C</td> <td>16, 923</td> <td>16, 923</td> <td>3, 609</td> <td>34, 002</td> <td>13.00</td>	13.00		C	16, 923	16, 923	3, 609	34, 002	13.00
INPATE FUT ROUTENT SERVICE COST CENTERS 0 0 000000000000000000000000000000000000			0					
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40.00 04.000 SUBPROVIDER 1 PF 0 1 1 0 1 0 0 0 0 0 0 1 0 1 0 1 0 0 0 0 0 0 0 0 0 1 <th1< th=""> 1 <th1< th=""> <th1< th=""></th1<></th1<></th1<>		03000 ADULTS & PEDIATRICS			1 1 1			
1:00 DURDROW LDER - IRF 0 233, 058 2.33, 058 4.152 59, 71 41.00 41:00 J4300 NURSERY 0<			C	265, 616	265, 616	8, 511		
42.00 0 <td></td> <td></td> <td></td> <td>233,058</td> <td>233.058</td> <td>4, 152</td> <td>-</td> <td></td>				233,058	233.058	4, 152	-	
MACILLARY SERVICE COST CENTERS Image: Control of State Cost Centers 0.0 000000 0	42.00		C		0			
50.00 05000 0PERATING ROOM 0 837,720 837,720 10,813 233,888 50.00 51.00 05100 RECOVERY ROM 0 0 0 0 51.00 51.00 05100 RECOVERY ROM 0 36,594 36,594 17,720 8,626 131,188 54.00 50.00 05500 MARNETIC RESONANCE IMAGING (MRI) 0 36,594 35,378 902 133,841 58.00 05000 GADIA CATHERERIZATION 0 122,547 122,547 2,699 61,232 59.00 06000 LABORATORY 0	43.00		C	0 0	0 0	4, 651	47, 145	43.00
51.00 05100 RECOVERY ROOM 0	50.00		C	837, 720	837.720	10, 813	233, 888	50.00
57. 00 05700 (CT SCAN 0 36, 594 1, 703 24, 517 57. 00 59. 00 05600 (ARR) TC C RESONANCE I MAGI NG (MRI) 0 122, 547 2, 699 61, 232 59. 00 6600 (ARR) TC RESONANCE I MAGI NG (MRI) 0 354, 316 73. 64 225, 101 60. 00 6000 (ARR) TC RESONANCE I MAGI NG (MRI) 0 354, 316 73. 64 225, 101 60. 00 71. 00 71. 00. 071. 00 71. 00. 071. 00. 071. 00 71. 00. 071. 00 71. 00. 071. 00. 070. 00 71. 00. 070. 00 71. 00. 070. 00 71. 00. 070. 00 71. 00. 070. 00 71. 00. 070. 00 71. 00. 070. 00 72. 00	51.00	05100 RECOVERY ROOM						51.00
58. 00 05800 (MAGRETI C RESONANCE LIMAGING (MRI) 0 43. 378 43. 378 902 13. 841 58. 00 60. 00 06000 (ARDI AC CATHETERI ZATION 0 354. 316 53. 436 7. 304 225. 101 60. 00 60. 01 06001 (DACDLOGY 0 0 3.197 42. 270 60. 01 60. 01 06001 (INTRAVENDIS) THERAPY 0 0 0 0 64. 00 64. 00 06400 (INTRAVENDIS) THERAPY 0 162. 958 5.555 80. 916 65. 66 60. 00 06000 (LECTROCARDI 0LOGY 0 170. 01 162. 958 15.255 80. 916 65. 60 60. 00 06000 (LECTROCARDI 0LOGY 0 173. 400 3. 233 35. 616 69. 00 71. 00 0 0 72. 00			C					
59. 00 05900 (CARDI AC CATHETERI ZATI ON 0 122, 547 2, 699 61, 222 59. 00 60. 00 06001 (ABORATORY) 0 354, 316 354, 316 7, 304 225, 101 60. 00 60. 01 06001 (NCOLOGY 0								
60.01 06001 06001 06001 06001 0 3, 197 42, 270 66. 01 66. 00 66. 286 66. 69. 00 69. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 0 71. 00 0 0 0 0 0 0 0 0 0 0 72. 00 <th7< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></th7<>			0					
60.02 RADIATION ONCOLOGY 0	60.00		C	354, 316				
64:00 064:00 INTRAVENUUS THERAPY 0 0 0 0 64:00 66:00 06600 PESPIR ATORY THERAPY 0 170,131 170,131 6,239 66,286 66:00 66:00 06600 PESPIR ATOR 0 170,131 170,131 6,239 66,286 66:00 60:00 06000 ELECTROCARDIOLOGY 0 193,400 3,233 35,616 69:00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71:00 07200 DRUGE CHARGED TO PATIENTS 0 0 0 0 72:00 72:00 72:00 72:00 72:01 83:2 25:52:2 90:00 92:00 92:01					0			
66.00 06600 PHYSICAL THERAPY 0 170.31 170.131	64.00				0	-	-	
69:00 06900 LECTROCARDIOLOGY 0 193,400 133,400 3,233 35,616 69:00 00:01 GORI CARDIA CREHAB 0 31,512 31,512 570 6,887 69:00 71:00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 71:00 0	65.00		C					
69:01 06400 CARDIAC REHAB 0 31, 512 31, 512 31, 512 570 6, 887 69, 01 71:00 07300 MPLL SCHARGED TO PATIENTS 0 0 0 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
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73.00 07300 DRUGS CHARGED 73.00 O 0 276.01 73.00 0UTPATLENT SERVICE COST CENTS 73.00 CENTS 73	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	0	0	0	71.00
OUTPATIENT SERVICE COST CENTERS Image: Cost Centers 90.00 09000 CLINIC 0 119,021 119,021 119,021 832 25,822 90.00 90.00 09000 CLINIC 0 269,190 269,190 269,434 227,614 91.00 92.00 09200 (DBSERVATION BEDS (INON-DISTINCT PART) 0 0 0 0 92.00 92.01 09200 (AMBULANCE SERVICES 0 100,907 100,907 4,055 44,733 95.00 09500 (AMBULANCE SERVICES 0 100,907 100,907 4,055 44,733 95.00 09500 (AMBULANCE SERVICES 0 100,907 100,907 4,055 44,733 95.00 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 10,833,857 187,437 2,520,675 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 102.01 192.01 19201 PACT REV PHYSICI ANS 0 0 0 0 1192.01			0					
90. 00 000000 CLINIC 0 119, 021 119, 021 119, 021 1322 25, 822 90. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 01	73.00			<u>/</u>	<u> </u>	0	270, 212	_ /3.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 <td></td> <td>09000 CLI NI C</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		09000 CLI NI C						
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I18.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 10,833,857 10,833,857 187,437 2,520,675 118.00 NORRE IMBURSABLE COST CENTERS 0 32,314 32,314 72 1,614 192.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 PACT REV PHYSI CLANS 0 0 0 0 192.00 192.02 VISI TOR MEALS 0 0 0 0 0 192.02 192.03 IPACT REV PHYSI CLANS 0 0 0 0 192.02 192.03 IPACT REV PHYSI CLANS 0 0 0 0 192.03 192.04 19204 LIFELINE 0 0 0 0 192.04 192.05 OWNED PROPERTIES 0 0 0 0 192.07 192.04 IPACIOAGY 0 0 0 0 0 192.07 192.05 IPACO IPACOAGY	113.00							113.00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 32, 314 32, 314 72 1, 614 190.00 192.00 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 0 192.01 192.02 VI SI TOR MEALS 0 0 0 0 0 192.02 192.03 19203 GREAT BEGI INNI NGS/MATERNAL 0 0 0 0 192.03 192.04 19204 LI FELI NE 0 0 0 0 192.04 192.05 19205 OWED PROPERTI ES 0 0 0 192.05 192.07 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.06 192.06 IRQUEG PROPERTI ES 0 0 0 0 192.07 192.07 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.07 192.08 19211 PARI SH NURSI NG 0 0 0		SUBTOTALS (SUM OF LINES 1 through 117)	C	10, 833, 857	10, 833, 857	187, 437	2, 520, 675	
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 192.01 19201 PACT REV PHYSI CLANS 0 0 0 20,615 192.01 192.02 19202 VI SI TOR MEALS 0 0 0 0 192.03 192.03 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 192.03 192.04 192.05 INPO 0 0 0 0 192.03 192.05 19205 WINED PROPERTIES 0 0 0 0 192.03 192.07 19207 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.07 192.08 19211 PARI SH NURSI NG 0 0 0 192.08 192.08 192.09 19212 BI OTERRORI SM GRANT 0 0 0 192.09 192.09 192.10 19214 BRAEST PUMPS 0 0 0 0 192.10 192.11 19208 MGH EXPRESS 0 0 0 0 192.12 1	100 00			22 214	22.214	70	1 414	100.00
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192.04 19204 LIFELINE 0 0 0 192.04 192.04 192.05 19205 0WNED PROPERTIES 0 0 0 12,625 192.05 192.06 19206 UROLOGY 0 0 0 3,152 37,868 192.06 192.07 19207 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.07 192.08 19211 PARISH NURSI NG 0 0 0 187 1,898 192.08 192.09 19212 BIOTERRORI SM GRANT 0 0 0 0 192.09 192.11 19208 MGH EMERGENCY PHYSICIANS 0 0 0 0 192.10 192.12 IOTERRORI SM GRANT 0 0 0 0 0 192.10 192.11 19208 MGH EMERGENCY PHYSICIANS 0 0 0 0 192.10 192.12 19209 LUNG CENTER 0 0 0 0 2,166 21,348 192.13 192.14 19210 MGH PHYS PRACT MGMT			0	0	0	-		
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192.13192.13MGH EXPRESS003,88543,815192.13192.1419210MGH PHYS PRACT MGMT0004,86473,920192.14192.1519215MGH MARI ON SURGEONS0005,85257,603192.15192.1619216MGH MGH MED ONC0004,21640,438192.16192.1719217MGH FMC SOUTH0004,21350,732192.17					0	0		
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192.16 192.16 MGH MGH MED ONC O O 40, 438 192. 16 192.17 19217 MGH FMC SOUTH O O 0 4, 213 50, 732 192. 17	192.14	19210 MGH PHYS PRACT MGMT	C		0	4, 864	73, 920	192.14
192. 17 19217 MGH FMC SOUTH 0 0 4, 213 50, 732 192. 17			0		0			
			C					

Health Financial Systems	MARION GENERA	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0011		eriod: com 07/01/2021 o 06/30/2022	Worksheet B Part II Date/Time Pre 11/30/2022 9:	pared:
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal		EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI V E & GENERAL	
		1.00	2A		4.00	5.00	
192. 19 19219 MGH FMC MARION 193. 00 19300 NONPAID WORKERS 193. 01 19301 MGH FMC GAS CITY 193. 02 19303 MGH HOSPITALISTS 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH PEDIATRIC CTR 193. 07 19307 MGH SPECIALTY PHYS 193. 08 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH 193. 10 19310 MGH MGH SYCHIATRY 193. 12 19312 OB/GYN 193. 15 19315 MGH NEONATOLOGY 193. 16 19316 MGH NEONATOLOGY 193. 16 19318 MGH WOUND CARE 194. 00 07963 HEART FAILURE CLINIC 194. 01 07955 MOW 194. 02 07951 MENTAL HEALTH 194. 03 07955 OPIOID IMPL GRANT 194. 04 0707954 MGH TAYLOR UNIVERSITY 194. 05 07954 MGH SMMP BLDG 194. 10 07055					$\begin{array}{c} 4.00\\ & 3,658\\ & 0\\ & 0\\ & 3,120\\ & 2,019\\ & 10,226\\ & 9,053\\ & 597\\ & 2,093\\ & 807\\ & 791\\ & 0\\ & 0\\ & 0\\ & 0\\ & 0\\ & 0\\ & 0\\ & $	$\begin{array}{c} 38,830\\ 0\\ 32,870\\ 24,825\\ 98,302\\ 96,789\\ 6,581\\ 23,651\\ 8,429\\ 9,998\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	193. 02 193. 03 193. 04 193. 05 193. 06 193. 07 193. 09 193. 10 193. 10 193. 12 193. 15 193. 16 193. 18 194. 00 194. 01 194. 02 194. 03
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum Lines 118 through 201)	0	0 10, 866, 171	10, 866, 7	0 0 171	0 263, 427	0 3, 399, 541	200. 00 201. 00 202. 00

Health Finan	cial Systems	MARI ON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 07/01/2021	Worksheet B Part II	
					06/30/2022		pared:
	Cost Center Description	MAINTENANCE &	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	
		REPAIRS 6.00	6. 01	6.02	PLANT 7.00	LINEN SERVICE 8.00	
	AL SERVICE COST CENTERS						
	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
	ADMINISTRATIVE & GENERAL						4.00 5.00
	MAINTENANCE & REPAIRS	0					6.00
	CAFETERI A	0	159, 118	457 4/0			6.01
	CAFETERIA OPERATION OF PLANT	0	157, 463 0	157, 463 5, 009			6.02 7.00
	LAUNDRY & LINEN SERVICE	0	0	5,009 C		86,058	
	HOUSEKEEPI NG	0	0	C		0	9.00
	DI ETARY NURSI NG ADMI NI STRATI ON	0	0	42		10, 194	
	CENTRAL SERVICES & SUPPLY	0	0	2, 662 1, 126		0	13.00 14.00
	PHARMACY	0	0	7, 808		0	15.00
	I ENT ROUTI NE SERVI CE COST CENTERS			05.54	404 005	10.010	
	ADULTS & PEDIATRICS	0	0	25, 544 6, 521		18, 240 4, 633	
	SUBPROVIDER - IPF	0	0	0, 521		4,035	40.00
	SUBPROVI DER – I RF	0	0	4, 192	112, 461	1, 941	41.00
	SUBPROVI DER	0	0	0	0	0	42.00
	NURSERY LARY SERVICE COST CENTERS	0	0	4, 480	0	0	43.00
50.00 05000	OPERATING ROOM	0	0	12, 922	404, 236	7, 522	50.00
	RECOVERY ROOM	0	0	0	-	0	51.00
	RADI OLOGY-DI AGNOSTI C CT SCAN	0	0	11, 262 2, 312		4, 844 2, 865	54.00 57.00
	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1, 224		2,005	58.00
59.00 05900	CARDI AC CATHETERI ZATI ON	0	0	3, 123		905	59.00
		0	0	10, 109		0	60.00
	ONCOLOGY RADIATION ONCOLOGY	0	0		Ű	269 0	60. 01 60. 02
	I NTRAVENOUS THERAPY	0	0	0	-	0	64.00
	RESPI RATORY THERAPY	0	0	4, 907		718	65.00
	PHYSI CAL THERAPY ELECTROCARDI OLOGY	0	0	3, 128 4, 799		1, 739 572	66.00 69.00
	CARDI AC REHAB	0	0	4, 799		572	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	0		-	0	72.00
	DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	0	0		0	0	73.00
90.00 09000	CLINIC	0	0	1, 290		164	90.00
	EMERGENCY	0	0	15, 609	129, 896	28, 763	
	OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	0	0	C	0	0	92.00 92.01
OTHER	REIMBURSABLE COST CENTERS	0				0	72.01
	AMBULANCE SERVICES	0	0	6, 626	48, 692	2, 466	95.00
	AL PURPOSE COST CENTERS						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	157, 463	135, 374	2, 371, 494	85, 836	118.00
	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0	98			190.00 192.00
	PACT REV PHYSICIANS	0	0	382			192.00
192.02 19202	VISITOR MEALS	0	1, 655	C	0	0	192.02
	GREAT BEGINNINGS/MATERNAL	0	0	0	0		192.03
192.04 19204	OWNED PROPERTIES	0	0		0		192. 04 192. 05
192.06 19206		0	0	2, 348	0		192.06
	PHYSICIANS' PRIVATE OFFICES	0	0	C	0		192.07
	PARI SH NURSI NG BI OTERRORI SM GRANT	0	0	245	0		192.08 192.09
	BREAST PUMPS	0	0		0		192.10
192.11 19208	MGH EMERGENCY PHYSI CLANS	0	0	C	0	0	192.11
		0	0	840	0		192.12
	MGH EXPRESS MGH PHYS PRACT MGMT	0	0	8, 452			192. 13 192. 14
192. 15 19215	MGH MARION SURGEONS	0	0	2, 954		17	192. 15
	MGH MGH MED ONC	0	0	0	0		192.16
	MGH FMC SOUTH MGH FAIRM MED ASSOC	0	0		0		192. 17 192. 18
	MGH FMC MARI ON	0	0	3, 313	0		192.10
	NONPAID WORKERS	0	0	C	0		193.00
	MGH FMC NORTHWOOD MGH FMC GAS CITY	0	0		Ű		193. 01 193. 02
175.02 17502		<u>।</u>	0		<u> </u>	15	1, 73. UZ

Heal th Financial Systems	MARION GENERA				u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 07/01/2021	Worksheet B Part II	
			lτ			pared:
					11/30/2022 9:	
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	0		193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	1, 598			193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	522	0		193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	-		193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0		193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0		193.10
193. 11 19311 MGH MGH PSYCHLATRY	0	0	0	0		193.11
193. 12 19312 OB/GYN	0	0	0	0		193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0		193. 15
193.16 19316 MGH NEONATOLOGY	0	0	0	0		193.16
193.18 19318 MGH WOUND CARE	0	0	0	0		193.18
194.0007963 HEART FAILURE CLINIC	0	0	0	0		194.00
194.0107950 MOW	0	0	0	-		194.01
194.0207951 MENTAL HEALTH	0	0	0			194.02
194. 03 07952 ADVERTI SI NG	0	0	558			194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0			194.04
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0	0	-		194.05
194. 06 07955 OPI 0I D I MPL GRANT	0	0	0	0		194.06
194. 07 07956 ASTHMA GRANT	0	0	0	-		194.07
194. 08 07957 MGH SMMP BLDG	0	0	0	-		194.08
194. 09 07958 MGH AMBUCARE BLDG	0	0	0	-		194.09
194. 10 07959 MGH 106 LYONS BLDG	0	0	0	-		194.10
194. 11 07960 FAI RMOUNT	0	0	0	-		194.11
194. 12 07961 GAS_CITY	0	0	0	-		194.12
194. 13 07969 LYONS	0	0	0	-		194.13
194. 14 07964 WABASH	0	0	0	0		194.14
194. 15 07965 TOBACCO GRANT	0	0	193			194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0	0	-		194.16
194. 17 07967 HRSA OPI OLD PLANNI NG	0	0	0	-		194.17
194. 18 07962 ECHO GRANT	0	0	13	0		194.18
194. 19 07968 RURAL QI GRANT	0	0	191 337	0		194.19
194.20 07970 MGH DIABETES GRANT 194.21 07971 MGH MGH ORTHO	0	0	337	0		194.20 194.21
	0	0	0	0		194.21
194. 22 07972 MGH BELLA BLDG	0	0	0	0		
194. 23 07973 DI ABETES GRANT 194. 24 07974 HEALTH SYS GRANT	0	0	45	0		194.23 194.24
194. 25 07975 MGH MGH ORTHO		0	40	0		194.24
	0	0	0	0	0	200.00
5	0	_	0	_		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	159, 118	157, 463	2, 387, 087		201.00
202.00 TOTAL (Sum TIMES TTO THE OUGH 201)	I U	137, 110	157,403	2, 307, 007	J 00, 006	202.00

Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 07/01/2021	Worksheet B Part II	
			To		Date/Time Pre	pared:
Cost Center Description	HOUSEKEEPING	DI ETARY	NURSI NG	CENTRAL	11/30/2022 9: PHARMACY	15 am
	HOUSEREEFFING	DIEMICI	ADMI NI STRATI O	SERVICES &		
	0.00	10.00	N 12.00	SUPPLY	15.00	
GENERAL SERVICE COST CENTERS	9.00	10.00	13.00	14.00	15.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5.00 6.00
6. 01 00601 CAFETERI A						6.01
6. 02 00602 CAFETERI A						6.02
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG	182, 350					9.00
10. 00 01000 DI ETARY	2, 612	273, 917				10.00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	816 4, 081	0	66, 178 757	107, 847		13.00 14.00
15. 00 01500 PHARMACY	2, 285	0	0	0, 047	232, 503	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	48, 325	148, 617	17, 164	11, 746	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	9, 142 0	27, 710 0	4, 382 0	5, 339 0	0	31.00 40.00
41. 00 04100 SUBPROVI DER - I RF	7, 836	23, 434	2, 817	1, 068	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, 010	0	0	43.00
50. 00 05000 OPERATING ROOM	24, 161	0	8, 683	22, 421	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	10, 366 571	0	0	1, 068 0	0	54.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	3, 265	0	2, 099	6, 407	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 ONCOLOGY	9, 142 0	0	0	6, 407 1, 068	0	60.00 60.01
60. 02 06002 RADIATION ONCOLOGY	0	0	0	1,008	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	6, 856	0	3, 525	2, 136	0	65.00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0 4, 408	0	2, 102 3, 225	0 3, 203	0	66.00 69.00
69. 01 06901 CARDI AC REHAB	4, 897	0	456	0	0	69.01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		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	0 232, 503	72.00 73.00
OUTPATIENT SERVICE COST CENTERS	-	-				
90. 00 09000 CLINIC	3, 265	0		0	0	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	36, 568	10, 312	10, 488	5, 339	0	91.00 92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	
OTHER REIMBURSABLE COST CENTERS			= -	1-		
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 143	0	4, 452	0	0	95.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 179, 739	210, 073	64, 027	66, 202	232, 503	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	326	0	0	0	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		192.00
192. 01 19201 PACT REV PHYSICIANS	0	0	0	0	0	192.01
192. 02 19202 VI SI TOR MEALS 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL	0	0	0 36	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, 271		192.06
192. 07 19207 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19211 PARI SH NURSI NG	653 326	0	0	0		192. 07 192. 08
192. 09 19212 BI OTERRORI SM GRANT	0	0	0	0	0	192.09
192. 10 19214 BREAST PUMPS	0	0	0	0		192.10
192. 11 19208 MGH EMERGENCY PHYSI CLANS 192. 12 19209 LUNG CENTER	0	0	0	0		192. 11 192. 12
192. 13 19213 MGH EXPRESS	0	0	2, 115	2, 136		192.12
192.14 19210 MGH PHYS PRACT MGMT	1, 306	0	0	0	0	192.14
192. 15 19215 MGH MARI ON SURGEONS 192. 16 19216 MGH MGH MED ONC	0	0	0	3, 203		192. 15 192. 16
192. 16 19216 MGH MGH MED ONC 192. 17 19217 MGH FMC SOUTH	0	0	0	3, 203		192.16
192.18 19218 MGH FAIRM MED ASSOC	0	0	Ő	0	0	192. 18
192. 19 19219 MGH FMC MARI ON	0	0	0	3, 203		192. 19 193. 00
193. 00 19300 NONPALD WORKERS 193. 01 19301 MGH FMC NORTHWOOD	0	0	0	0 1, 068		193.00 193.01
· · · ·		-			-	

Health Financial Systems	MARION GENERAL				u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0011	Period: From 07/01/2021	Worksheet B Part II
				To 06/30/2022	Date/Time Prepared: 11/30/2022 9:15 am
Cost Center Description	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY
			ADMI NI STRATI		
			N	SUPPLY	
	9.00	10.00	13.00	14.00	15.00
193.02 19302 MGH FMC GAS CITY	0	0		0 1, 068	0 193.02
193. 03 19303 MGH HOSPI TALI STS	0	0		0 0	0 193.03
193.04 19304 MGH MAR FAM PRACT	0	0		0 6, 407	0 193.04
193.05 19305 MGH_FMC_SWAYZEE	0	0		0 1, 068	0 193.05
193.06 19306 MGH PEDIATRIC CTR	0	0		0 1, 068	0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	0		0 0	0 193.07
193.08 19308 MGH FMC CONVERSE	0	0		0 1, 068	0 193.08
193.09 19309 MGH UPLAND HEALTH	0	0		0 0	0 193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0 0	0 193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0		0 0	0 193. 11
193. 12 19312 OB/GYN	0	0		0 10, 678	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
194.0107950 MOW	0	42, 876		0 0	0 194.01
194.0207951 MENTAL HEALTH	0	20, 968		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 2, 136	0 194.04
194.0507954 MGH TAYLOR UNIVERSITY	0	0		0 0	0 194.05
194.06079550PIOLD IMPL GRANT	0	0		0 0	0 194.06
194.0707956ASTHMA GRANT	0	0		0 0	0 194.07
194.08 07957 MGH_SMMPBLDG	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 1, 068	0 194. 12
194. 13 07969 LYONS	0	0		0 0	0 194. 13
194.14 07964 WABASH	0	0		0 0	0 194.14
194.1507965 TOBACCO GRANT	0	0		0 0	0 194. 15
194.1607966 HRSA NETWORK DEV PLANNING	0	0		0 0	0 194. 16
194.1707967HRSA OPIOID PLANNING	0	0		0 0	0 194. 17
194.1807962 ECHO GRANT	0	0		0 0	0 194. 18
194.1907968 RURAL QI GRANT	0	0		0 0	0 194. 19
194.2007970 MGH DIABETES GRANT	0	0		0 0	0 194. 20
194.21 07971 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	0		0 0	0 194.23
194.2407974 HEALTH SYS GRANT	0	0		0 0	0 194. 24
194.2507975 MGH MGH ORTHO	0	0		0 0	0 194. 25
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	182, 350	273, 917	66, 1	78 107, 847	232, 503 202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	MARION GENERA	AL HOSPITAL Provider CCI	N: 15-0011 P	In Lieu of Form CMS eriod: Worksheet B	
						repared:
	Cost Center Description	Subtotal	Intern &	Total	11/30/2022	9:15 am
		Subtotal	Residents	Total		
			Cost & Post Stepdown			
			Adjustments			
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS					5.00 6.00
6.00	00600 MATNTENANCE & REPATRS					6.00
6.02	00602 CAFETERI A					6. 02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00 8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13.00 14.00
	01500 PHARMACY					15.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 128, 462 584, 025	0	2, 128, 462 584, 025		30.00 31.00
	04000 SUBPROVI DER – I PF	584, 025	0	564, 025 0		40.00
41.00	04100 SUBPROVI DER – I RF	450, 330	0	450, 330		41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 59, 286	0	0 59, 286		42.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	59,200	U	39,200		43.00
50.00	05000 OPERATING ROOM	1, 562, 366	0	1, 562, 366		50.00
51.00 54.00	05100 RECOVERY ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 913, 039	0	0 913, 039		51.00 54.00
57.00	05700 CT SCAN	86, 220	0	86, 220		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	80, 277	0	80, 277		58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	261, 411 783, 352	0	261, 411 783, 352		59.00 60.00
60.00	06001 ONCOLOGY	46, 804	0	46, 804		60.00
60. 02	06002 RADIATION ONCOLOGY	0	0	0		60. 02
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 346, 215	0	0 346, 215		64.00 65.00
	06600 PHYSI CAL THERAPY	340, 215	0	331, 721		66.00
69.00	06900 ELECTROCARDI OLOGY	341, 780	0	341, 780		69.00
69. 01 71. 00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	60, 207 0	0	60, 207 0		69.01 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	508, 715	0	508, 715		73.00
00 00	OUTPATIENT SERVICE COST CENTERS	208, 694	0	208, 694		90.00
	09100 EMERGENCY	763, 213	0	763, 213		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0		92.01
95.00	09500 AMBULANCE SERVICES	213, 074	0	213, 074		95.00
	SPECIAL PURPOSE COST CENTERS					
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	9, 729, 191	0	9, 729, 191		113.00 118.00
110.00	NONREI MBURSABLE COST CENTERS	7,727,171	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 017	0	50, 017		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 PACT REV PHYSI CLANS	0 23, 016	0	0 23, 016		192.00 192.01
	19202 VI SI TOR MEALS	1, 655	0	1, 655		192.02
	19203 GREAT BEGI NNI NGS/MATERNAL	547	0	547		192.03
	19204 LIFELINE 19205 OWNED PROPERTIES	0 12, 625	0	0 12, 625		192.04 192.05
	19206 UROLOGY	47, 639	0	47,639		192.06
	19207 PHYSICIANS' PRIVATE OFFICES	653	0	653		192.07
	19211 PARI SH NURSI NG 19212 BI OTERRORI SM GRANT	2, 656 0	0	2, 656 0		192.08 192.09
192.10	19214 BREAST PUMPS	0	0	0		192.10
	19208 MGH EMERGENCY PHYSI CLANS	0	0	0		192.11
	19209 LUNG CENTER 19213 MGH EXPRESS	24, 354 52, 050	0	24, 354 52, 050		192. 12 192. 13
	19210 MGH PHYS PRACT MGMT	88, 542	0	88, 542		192.14
	19215 MGH MARI ON SURGEONS	69, 629	0	69, 629		192.15
	19216 MGH MGH MED ONC 19217 MGH FMC SOUTH	44, 654 58, 156	0	44, 654 58, 156		192. 16 192. 17
192.18	19218 MGH FAIRM MED ASSOC	10, 060	0	10, 060		192.18
192.19	19219 MGH FMC MARION	49, 013	0	49, 013		192.19

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: Worksheet B From 07/01/2021 Part II To 06/30/2022 Date/Time Prepared: 11/30/2022 9:15 am
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
193. 00 19300 NONPAI D WORKERS 193. 01 19301 MGH FMC NORTHWOOD 193. 02 19302 MGH FMC GAS CI TY 193. 03 19303 MGH HOSPI TALI STS 193. 04 19304 MGH MAR FAM PRACT 193. 05 19305 MGH FMC SWAYZEE 193. 06 19306 MGH FMC SWAYZEE 193. 07 19307 MGH SPECI ALTY PHYS 193. 08 19308 MGH FMC CONVERSE 193. 09 19309 MGH UPLAND HEALTH 193. 10 19310 MGH MGH WOMENS CTR 193. 12 19312 OB/GYN 193. 12 19315 MGH RI VER VI EW BLDG 193. 15 19316 MGH NEONATOLOGY 193. 16 19318 MGH WOUND CARE 194. 00 07963 HEART FAI LURE CLINIC 194. 01 07950 MOW 194. 02 07951 MENTAL HEALTH 194. 03 07952 ADVERTI SI NG 194. 04 07953 MGH WORK SOLUTI ONS 194. 06 07955 OFI OI D I MPL GRANT 194. 06 079	24:00 37,058 27,927 108,528 112,313 8,246 28,413 9,758 11,859 0 0 0 0 0 0 0 0 0 0 0 0 0	22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37, 05; 27, 92 108, 52; 112, 31; 8, 24; 28, 41; 9, 75; 11, 85; (85, 81; 20, 62; 80; 1, 57; 42, 87; 20, 96; 4, 99; 22, 02; (10, 59;	7 193.02 8 193.03 3 193.04 6 193.05 3 193.06 9 193.07 9 193.08 193.09 193.10 193.12 193.12 193.12 193.13 193.15 193.15 193.16 193.16 193.18 194.00 194.01 194.02 194.02 194.03 9 194.04 9 194.05
	-		1, 068 (1, 986 (677 2, 133 333 (200 41 40, 875 (0 (0 (0 (0 (0 (0 (0 (0 (0 (194.08 194.09 194.10 194.11 194.11 194.11 194.13 194.13 194.14 194.15 194.16 194.17 194.18 194.20 194.21 194.22 194.23 194.23 194.24 20.00 20.00 20.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MARION GENERA	L HOSPITAL Provider C	CN: 15-0011 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
0001 /				F	rom 07/01/2021 o 06/30/2022		
				· · ·	00,00,2022	11/30/2022 9:	
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		1.00	SALARI ES) 4.00	5A	5.00	6.00	
	GENERAL SERVICE COST CENTERS	1.00	4.00	5/	5.00	0.00	
1.00 4.00 5.00 6.00 6.01 6.02	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00601 CAFETERIA 00602 CAFETERIA	446, 894 10, 834 138, 038 0 4, 857 0	82, 569, 173 13, 522, 086 0 0 0	-29, 890, 781	0	298, 022	1.00 4.00 5.00 6.00 6.01 6.02
7.00 8.00 9.00 10.00 13.00 14.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	89, 714 2, 113 3, 260 6, 692 696 2, 383	906, 531 0 20, 364 1, 131, 360 177, 837		1, 463, 844 663, 552	2, 113 3, 260 6, 692 696 2, 383	7.00 8.00 9.00 10.00 13.00 14.00
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	3, 070	2, 673, 361	0	4, 443, 545	3,070	15.00
31.00 40.00 41.00 42.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY	42, 294 10, 924 0 9, 585 0 0	8, 190, 869 2, 667, 899 0 1, 301, 420 0 1, 457, 910		5, 338, 397 0 2, 556, 019 0	10, 924 0	31.00 40.00 41.00 42.00
50.00	ANCI LLARY SERVI CE COST CENTERS	34, 453	3, 389, 562	0	10, 069, 215	34, 453	50.00
51.00 54.00 57.00 58.00 59.00 60.00 60.01	05100 RECOVERY ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 ONCOLOGY 06002 RADIATION ONCOLOGY	04, 433 020, 686 1, 505 1, 784 5, 040 14, 572 0	2, 703, 987 533, 758 282, 638 845, 957 2, 289, 657 1, 002, 113		0 5, 647, 836 1, 055, 496 595, 880 2, 636, 148 9, 690, 921 1, 819, 772	0 20, 686 1, 505 1, 784 5, 040 14, 572	51.00 54.00 57.00 58.00 59.00 60.00
64.00 65.00 66.00 69.00 69.01 71.00 72.00	06400 I NTRAVENOUS THERAPY 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	0 0 6, 702 6, 997 7, 954 1, 296 0 0 0 0	1, 744, 605 1, 955, 656 1, 013, 389 178, 549 0 0 0		0 3, 483, 560 2, 853, 697 1, 533, 303 296, 516 0 0	0 6, 702 6, 997 7, 954 1, 296 0 0	64.00 65.00 66.00 69.00 69.01 71.00 72.00
90.00	OUTPATIENT SERVICE COST CENTERS	4, 895	260, 768	C	1, 111, 678	4, 895	90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	11, 071	9, 227, 068	C	9, 799, 104		91.00 92.00
95.00	09500 AMBULANCE SERVICES	4, 150	1, 271, 042	C	1, 925, 834	4, 150	95.00
113. 00 118. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	445, 565	58, 748, 386	-29, 890, 781	108, 520, 722	296, 693	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	22, 541 0 633, 022 0			0	190. 00 192. 00 192. 01 192. 02
192. 04 192. 05 192. 06	19203 GREAT BEGI NNI NGS/MATERNAL 19204 LI FELI NE 19205 OWNED PROPERTI ES 19206 UROLOGY	0 0 0	16, 047 0 0 987, 947		19, 824 0 543, 523 1, 630, 275	0 0 0	192.03 192.04 192.05 192.06
192. 08 192. 09 192. 10 192. 11	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 19209 LUNG CENTER		0 58, 636 0 0 0 679, 053		0 81, 717 0 0 0 919, 058	0 0 0	192. 07 192. 08 192. 09 192. 10 192. 11 192. 12
192. 13 192. 14 192. 15 192. 16	19213 MGH EXPRESS 19210 MGH PHYS PRACT MGMT 19215 MGH MARI ON SURGEONS 19216 MGH MGH MED ONC 19217 MGH FMC SOUTH		1, 217, 718 1, 524, 652 1, 834, 381 1, 321, 611 1, 320, 583		1, 886, 315 3, 182, 346 2, 479, 900 1, 740, 912 2, 184, 103	0 0 0	192. 13 192. 14 192. 15 192. 16 192. 17

ealth Financial Systems DST ALLOCATION - STATISTICAL	BASIS	MARION GENERA	Provider C	CN: 15-0011 F	Period:	u of Form CMS-2 Worksheet B-1	
	bior o			F	rom 07/01/2021		
					o 06/30/2022	Date/Time Pre 11/30/2022 9:	
		CAPI TAL	i				
		RELATED COSTS					
Cost Center Descr	i pti on	NEW BLDG &	EMPLOYEE		ADMI NI STRATI V		
		FLXT	BENEFITS	n	E & GENERAL	REPAI RS	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS SALARI ES)		COST)	FEET)	
		1.00	4.00	5A	5.00	6.00	-
92.18 19218 MGH FAIRM MED ASS	00	0	251, 700				192
92.19 19219 MGH FMC MARION		0	1, 146, 735		1, 671, 675	0	192
93.00 19300 NONPALD WORKERS		0	0	C	0 0	0	193
93.01 19301 MGH_FMC_NORTHWOOD		0	978, 044	C	1, 415, 123		193
93.02 19302 MGH FMC GAS CITY		0	633, 014	C	1, 068, 771		193
93. 03 19303 MGH HOSPI TALI STS		0	3, 205, 794		1,202,000		193
93.04 19304 MGH MAR FAM PRACT		0	2,838,018		.,		193
93.05 19305 MGH FMC SWAYZEE		0	187, 167	C			193
93. 06 19306 MGH PEDIATRIC CTF		0	656, 086		1 1 -		193
93.07 19307 MGH SPECIALTY PHY 93.08 19308 MGH FMC CONVERSE	3	0	252, 889 247, 858				193 193
93.09 19309 MGH UPLAND HEALTH		0	247, 838				193
P3. 10 19310 MGH MGH WOMENS CT		0	0				193
93. 11 19311 MGH MGH PSYCHIATE		0	0				193
93. 12 19312 OB/GYN		0	1, 923, 259	-	-		193
93.1519315 MGH RIVER VIEW BL	DG	0	0	C			193
3. 16 19316 MGH NEONATOLOGY		0	0	C	888, 000	0	193
3.18 19318 MGH WOUND CARE		0	23, 985	c	31, 524	0	193
4.0007963 HEART FAILURE CLI	NIC	0	36, 279	C	62, 684	0	194
94. 01 07950 MOW		0	0	C	0 0	0	194
94.0207951 MENTAL HEALTH		0	0	C	0 0	0	194
94. 03 07952 ADVERTI SI NG		0	132, 574				194
94.0407953 MGH WORK SOLUTION		0	398, 021	C			194
94. 05 07954 MGH TAYLOR UNIVER		0	0	C			194
94. 06 07955 OPI OLD IMPL GRANT		0	42, 652	C			194
94.07 07956 ASTHMA_GRANT 94.08 07957 MGH_SMMPBLDG		0	0		-		194 194
94.0907958 MGH AMBUCARE BLDG		0	0				194
94. 10 07959 MGH 106 LYONS BLD		0	0		-		194
94. 11 07960 FAI RMOUNT		0	0				194
94. 12 07961 GAS_CITY		0	0		0 0		194
94. 13 07969 LYONS		0	0	C	0		194
94.1407964 WABASH		0	0	c c	0 0	0	194
94.1507965 TOBACCO GRANT		0	34, 708	C	72, 422	0	194
94.1607966 HRSA NETWORK DEV		0	0	C	0 0		194
94.1707967HRSA OPIOID PLANN	I NG	0	0	C	-		194
24. 18 07962 ECH0 GRANT		0	1, 924		28, 331		194
4. 19 07968 RURAL QI GRANT	т	0	25, 334				194
04.20 07970 MGH DIABETES GRAM 04.21 07971 MGH MGH ORTHO	1	0	0	C	0		194 194
94. 2107971 MGH MGH ORTHO 94. 2207972 MGH BELLA BLDG		0	0		0		194
94. 23 07973 DI ABETES GRANT		0	0		8,779		194
24. 24 07974 HEALTH SYS GRANT		0	0				194
4. 25 07975 MGH MGH ORTHO		0	1, 188, 555	-	-		194
0.00 Cross Foot Adjust	ments	Ĵ	1, 100, 000		1,0,0,110		200
1.00 Negative Cost Cer					1		201
02.00 Cost to be alloca		10, 866, 171	16, 835, 022		29, 890, 781	0	202
Part I)	•• •		· · ·				
	ier (Wkst. B, Part I)	24. 314873	0. 203890		0. 204232		
04.00 Cost to be alloca	ted (per Wkst. B,		263, 427		3, 399, 541	0	204
Part II)							
	ier (Wkst. B, Part		0. 003190		0. 023228	0. 000000	205
	mount to be allocated						206
(per Wkst. B-2)	ltiplier (Wkst. D,						207
07.00 NAHE unit cost mu	litipiler (WKST. D,				1	1	207

From 07/01/2021 bits/Time_Propared. 11/28/EEPIA (POUNDS of 00100 NEW CAP REL COSTS CENTERS CAFETERIA (WEALS SERVED) OPERATION oF PLANT (POUNDS of PLANT (POUNDS oF PLANT (POUNDS OF PERATION 00100 NEW CAP REL COSTS CENTERS I.ou 00100 NEW CAP REL COSTS CENTERS I.ou 0000000 NEW CAP REL COST CENTERS I.ou 000000000 NEW CAP REL COST CENTERS I.ou 00000000 NEW CAP REL COST CENTERS I.ou 00000000000 NEW CAP	Heal th Financial		MARION GENERAL		CN. 15 0011 D		u of Form CMS-	
Cost Center Description CAFETERIA (VEALS SERVED) CAFETERIA (VEALS SERVED) CAFETERIA (VEALS WORKED) CALUNDRY (PLANT FEET) NOUNCEY (PLANT FEET) NOUNCEY (PLANT FEET) <	CUST ALLUCATION -	- STATISTICAL BASIS		Provider C	F	rom 07/01/2021		epared:
6.01 6.02 7.00 8.00 9.00 1.00 00100 NEW CAP REL COSTS -BLIDC & FLIXT 4.00	Cost	t Center Description	(MEALS	(HOURS	PLANT (SQUARE	LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF	<u>15 am</u>
1. 00 00100 NEW CAP REL 00STS-BLDC & FLYT 1. 00 1. 00 00500 PMD, VAP REL 00STS-BLDC & FLYT 1. 00 4. 00 00500 PMD, VAP REL 00STS-BLDC & FLYT 1. 170, 660 5. 00 0. 00500 PMD, VAP REL 00STS-BLDC & FLYT 1. 170, 660 5. 00 00500 PMD, VAP REL 00STS-BLDC & FLYT 233, 831 1. 170, 660 6. 00 6. 00 00500 PMD, VAP REL 00STS-BLDC & FLYT 0 37, 242 203, 451 7. 00 6. 00 00500 PMD, VAP REL NAN SERVICE 0 0 3, 260 0 58, 084 9. 00 9. 00 00900 AUUSEKEPI NG 0 19, 782 666 0 2260 13. 00 10. 00 01000 DIETARY 0 68, 374 2. 333 12 1. 300 14. 00 14. 00 17874 2. 383 12 1. 300 14. 00 14. 00 14. 943 15, 392 30. 00 30. 00 30. 00 30. 00 30. 00 2. 294 154, 943 15, 392 30. 00 30. 00 0 0 0 0 0 0 0 0			6. 01	6.02			9.00	
4.00 00400[EMPLVEE BENEFITS DEPARTMENT 4.00 5.00 00500[AMM IN STRATI VE & GEPARIAS 5.00 6.01 00601[CAFETERI A 233,2831 7.00 07000[CAFETERI A 233,831 7.00 0700 0 3,226 8.00 0.00 0.2326 286,601 882 8.010 0.00 0.2333 12 1,300 14.00 10.00 0.1000[CHTRAL SERVICES & SUPPLY 0 8,374 2,383 12 1,300 11.00 0.3000[AULTS & PEDIATRICS 0 189,917 42,294 154,943 15,902 30.00 0.000 0.3000[AULTS & PEDIATRICS 0			T T					1 1 00
30:00 03000 ADULTS & PEDIATRICS 0 189,917 42,294 154,943 15,392 20.00 31:00 03100 INTENSIVE CARE UNIT 0 48,480 10,924 39,358 2,912 31.00 40:00 04000 SUBPROVIDER - IPF 0	4.00 00400 EMPLC 5.00 00500 ADMI N 6.01 00600 MAI N 6.02 00602 CAFE 7.00 00700 OPERV 8.00 00800 LAUNI 9.00 00900 HOUSE 10.00 01000 DI ET/ 13.00 01300 NURSI 14.00 01400 CENTF 15.00 01500 PHARM	LOYEE BENEFITS DEPARTMENT INISTRATIVE & GENERAL NTENANCE & REPAIRS ETERIA RATION OF PLANT NDRY & LINEN SERVICE SEKEEPING TARY SING ADMINISTRATION TRAL SERVICES & SUPPLY RMACY	233, 831 0 0 0 0 0 0 0 0	37, 242 0 313 19, 792 8, 374	203, 451 2, 113 3, 260 6, 692 696 2, 383	0 86, 601 0 12	832 260 1, 300	$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 01\\ 6.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$
31.00 03100 INTENSIVE CARE UNIT 0 48,480 10,924 39,358 2,912 31.00 40.00 04000 SUBPROVI DER - I RF 0			0	189 917	42 294	154 943	15 392	30.00
50.00 05000 OPERATING ROOM 0 96,072 34,453 63,901 7,696 50.00 51.00 DS100 RECOVERY ROOM 0 0 0 0 0 51.00 54.00 DS400 RADI OLOGY-DI AGNOSTI C 0 83,724 20,686 41,152 3,302 54.00 57.00 OS700 CT SCAN 0 17,185 1,505 24,341 182 57.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 9,100 1,784 0 0 58.00 59.00 05900 CARDI AC CATHETERIZATI ON 0 2,912 60.00 59.00 2,912 60.00 59.00 2,912 60.00 59.00 2,912 60.00 60.01 0 0 0 0 0 60.01 60.01 0000 LABRATORY 0 0 0 0 60.01 60.00 60.00 60.00 60.01 60.01 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00	31.00 03100 I NTEN 40.00 04000 SUBPF 41.00 04100 SUBPF 42.00 04200 SUBPF 43.00 04300 NURSF	ENSIVE CARE UNIT PROVIDER - IPF PROVIDER - IRF PROVIDER SERY	0 0 0 0	48, 480 0 31, 169 0	10, 924 0 9, 585 0	39, 358 0 16, 485 0	2, 912 0 2, 496 0	31.00 40.00 41.00 42.00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 83,724 20,686 41,152 3,302 54.00 57.00 05700 CT SCAN 0 17,185 1,505 24,341 182 57.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 9,100 1,784 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 23,220 5,040 7,689 1,040 59.00 60.01 06001 NCOLOGY 0			0	96, 072	34, 453	63, 901	7, 696	50.00
60.00 06000 LABORATORY 0 75, 155 14, 572 0 2, 912 60.00 60.01 06001 ONCOLOGY 0 0 0 0 2, 283 0 60.01 60.02 06002 RADIATION ONCOLOGY 0 0 0 0 0 60.02 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 36, 481 6, 702 6, 099 2, 184 65.00 66.00 06600 PHYSI CAL THERAPY 0 35, 678 7, 954 4, 859 1, 404 69.00 69.01 06901 CARDIAC REHAB 0 5, 048 1, 296 0 1, 560 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 72.00 0 0 72.00 72.00 0 0 0 72.00 0 0 0 0 72.00 72.00 72.00 0 0 0 0 <t< td=""><td>51.00 05100 RECO 54.00 05400 RADI 0 57.00 05700 CT S0 58.00 05800 MAGNE</td><td>DVERY ROOM I OLOGY-DI AGNOSTI C SCAN NETI C RESONANCE I MAGI NG (MRI)</td><td>0 0 0</td><td>0 83, 724 17, 185 9, 100</td><td>0 20, 686 1, 505 1, 784</td><td>0 41, 152 24, 341 0</td><td>0 3, 302 182 0</td><td>51.00 54.00 57.00 58.00</td></t<>	51.00 05100 RECO 54.00 05400 RADI 0 57.00 05700 CT S0 58.00 05800 MAGNE	DVERY ROOM I OLOGY-DI AGNOSTI C SCAN NETI C RESONANCE I MAGI NG (MRI)	0 0 0	0 83, 724 17, 185 9, 100	0 20, 686 1, 505 1, 784	0 41, 152 24, 341 0	0 3, 302 182 0	51.00 54.00 57.00 58.00
60.02 06002 RADI ATI ON ONCOLOGY 0 <td< td=""><td>60.00 06000 LABOF</td><td>DRATORY</td><td>0</td><td></td><td></td><td>-</td><td></td><td></td></td<>	60.00 06000 LABOF	DRATORY	0			-		
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 36,481 6,702 6,099 2,184 65.00 66.00 06600 PHYSI CAL THERAPY 0 23,253 6,997 14,776 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 35,678 7,954 4,859 1,404 69.00 69.01 06901 CARDI AC REHAB 0 5,048 1,296 0 1,560 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00			0			_		1
71.00 07100 MEDI 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 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 73.00 90.00 09000 CLINIC 0 9,590 4,895 1,391 1,040 90.00 91.00 09100 EMERGENCY 0 116,045 11,071 244,324 11,648 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 116,045 11,071 244,324 11,648 92.00	64.00 06400 I NTR/ 65.00 06500 RESPI 66.00 06600 PHYSI 69.00 06900 ELECT	RAVENOUS THERAPY PI RATORY THERAPY SI CAL THERAPY CTROCARDI OLOGY	0 0 0 0 0	0 36, 481 23, 253 35, 678	6, 702 6, 997 7, 954	0 6, 099 14, 776 4, 859	0 2, 184 0 1, 404	64.00 65.00 66.00 69.00
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0 9,590 4,895 1,391 1,040 90.00 91. 00 09100 EMERGENCY 0 116,045 11,071 244,324 11,648 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 92.00	71.00 07100 MEDI 0 72.00 07200 I MPL.	CAL SUPPLIES CHARGED TO PATIENTS DEV. CHARGED TO PATIENTS		0	0	0	0	71.00 72.00
91. 00 09100 EMERGENCY 0 116, 045 11, 071 244, 324 11, 648 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00	OUTPATI ENT	T SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	91.00 09100 EMERO 92.00 09200 OBSE	RGENCY ERVATION BEDS (NON-DISTINCT PART)	0	116, 045	11, 071	244, 324	11, 648	91.00 92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 OTHER REIMBURSABLE COST CENTERS			0	0	0	0	0	92.01
	95.00 09500 AMBUI	JLANCE SERVICES	0	49, 261	4, 150	20, 945	364	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 233, 831 1, 006, 448 202, 122 729, 159 57, 252 118.00	118.00 SUBTO	TOTALS (SUM OF LINES 1 through 117)	233, 831	1,006,448	202, 122	729, 159	57, 252	113. 00 118. 00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 728 1, 329 0 104 190.00			0	728	1.329	0	104	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 0 192.00	192.00 19200 PHYSI	SICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 PACT_REV_PHYSICIANS 0 2,842 0 0 0 192.01 192.02 VISITOR_MEALS 2,458 0 0 0 0 192.02			0	2, 842	0	0		1
192. 02 19202 VI SI TOK MEALS 2, 438 0 0 0 0 0 0 0 0 192. 02 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 0 0 0 0 0 0 0 0 0 0 0 0 0 0 192. 03				0	0	0		
192.04 19204 LI FELI NE 0 0 0 0 0 192.04			0	0	0	0	0	192.04
192.05 OWNED PROPERTIES O			0	0 17 454	0	0		
192. 00 19200 0K0L001 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	17, 434	0	0		
192.08 19211 PARISH NURSING 0 1,819 0 0 104 192.08	192.08 19211 PARI S	SH NURSING	0	1, 819	0	0	104	192.08
192.09/19212/BIOTERRORI SM GRANT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
192.10 19214 BREAST PUMPS 0 0 0 0 0 192.10 192.11 19208 MGH EMERGENCY PHYSICIANS 0 0 0 0 192.11			0	0	0	0		
192. 12 19209 LUNG CENTER 0 6, 243 0 0 192. 12	192.12 19209 LUNG	G CENTER	0	6, 243	0		0	192.12
192.13 19213 MGH EXPRESS 0 0 192.13			0	0	0			
192.14 19210 MGH PHYS PRACT MGMT 0 62,840 0 0 416 192.14 192.15 INGH MARI ON SURGEONS 0 21,962 0 146 0 192.15						-		
192.16 19216 MGH MGH MED ONC 0 0 0 192.16	192.16 19216 MGH M	MGH MED ONC	0	0	0	0	0	192.16
192.17 19217 MGH FMC SOUTH 0 0 0 66 0 192.17			0	0	0			
192.18 MGH_FALRM_MED_ASSOC 0 0 0 20 0 192.18 192.19 MGH_FALRM_MED_ASSOC 0 0 24, 628 0 74 0 192.19			0	0 24 628	, v			
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 0 193. 00			0	0				

Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
				rom 07/01/2021 o 06/30/2022	Date/Time Pre	nared
				0 00/30/2022	11/30/2022 9:	
Cost Center Description	CAFETERI A	CAFETERI A	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	(MEALS	(HOURS	PLANT	LINEN SERVICE	(HOURS OF	
	SERVED)	WORKED)	(SQUARE	(POUNDS OF	SERVICE)	
	(01	(02	FEET)	LAUNDRY)	0.00	
193.01 19301 MGH FMC NORTHWOOD	6. 01 0	<u> 6. 02 </u>	7.00	8.00	9.00	193.01
193. 02 19302 MGH FMC GAS CITY	0	0		130		193.02
193. 03 19303 MGH HOSPI TALI STS	0	0	0	0		193.02
193. 04 19304 MGH MAR FAM PRACT	0	0	, °	547		193.04
193. 05 19305 MGH FMC SWAYZEE	0	0		0		193.05
193. 06 19306 MGH PEDI ATRI C CTR	0	11, 879		27		193.06
193.07 19307 MGH SPECIALTY PHYS	0	3, 883		0	0	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	17	0	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	0	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193. 11 19311 MGH MGH PSYCHLATRY	0	0	0	0	0	193.11
193. 12 19312 OB/GYN	0	0	0	0		193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0		193.15
193. 16 19316 MGH NEONATOLOGY	0	0	0	0		193.16
193. 18 19318 MGH WOUND CARE	0	0	0	0		193.18
194. 00 07963 HEART FAILURE CLINIC	0	0	0	0		194.00
194.01 07950 MOW 194.02 07951 MENTAL_HEALTH	0	0	, o	0		194.01 194.02
194. 02 07951 MENTAL_HEALTH 194. 03 07952 ADVERTI SI NG	0	4, 145		0		194.02
194. 04 07953 MGH WORK SOLUTIONS	0	4, 143		26		194.03
194. 05 07954 MGH TAYLOR UNI VERSI TY	0	0		0		194.05
194. 06 07955 OPI OLD I MPL GRANT	0	0	0	0		194.06
194. 07 07956 ASTHMA GRANT	0	0	0	0		194.07
194. 08 07957 MGH SMMP BLDG	0	0	0	0		194.08
194.0907958 MGH AMBUCARE BLDG	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		194.13
194.1407964 WABASH	0	0		0		194.14
194. 15 07965 TOBACCO GRANT	0	1, 437		0		194.15
194. 16 07966 HRSA NETWORK DEV PLANNING	0	0	-	0		194.16
194. 17 07967 HRSA_0PIOLD_PLANNING 194. 18 07962 ECH0_GRANT	0	0 94		0		194.17
194. 19 07962 ECHU GRANT 194. 19 07968 RURAL_QI_GRANT	0	94 1, 419		0		194.18 194.19
194. 20 07970 MGH DI ABETES GRANT	0	2, 502		0		194.19
194. 21 07971 MGH MGH ORTHO	0	2, 302		0		194.20
194. 22 07972 MGH BELLA BLDG	0	0	0	0		194.22
194. 23 07973 DI ABETES GRANT	Ő	0	0	0		194.23
194. 24 07974 HEALTH SYS GRANT	0	337	0	0		194.24
194.2507975 MGH MGH ORTHO	0	0		0	0	194.25
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	2, 126, 666	2, 104, 543	10, 321, 732	619, 900	3, 526, 618	202.00
Part I)	0 0000	4	F0 70007-5	0.04767		000 00
203.00 Unit cost multiplier (Wkst. B, Part I)	9.000275	1. 797741				
204.00 Cost to be allocated (per Wkst. B,	159, 118	157, 463	2, 387, 087	86, 058	182, 350	204.00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	0. 673404	0 124500	11 70000	0 117710	2 120/10	205 00
205.00 Unit cost multiplier (Wkst. B, Part	0.0/3404	0. 134508	11. 732982	0. 117718	3. 139419	205.00
206.00 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)						
	· · ·			1	1	

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	MARION GENER	AL HOSPITAL	CN: 15-0011 P	In Lie eriod:	u of Form CMS-2552-10 Worksheet B-1
Sign Accounter Statistical Datis				rom 07/01/2021	Date/Time Prepared:
Cost Center Description	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	11/30/2022 9:15 am
	10.00	13.00	14.00	15.00	
GENERAL SERVI CE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS 6. 01 00601 CAFETERI A 6. 02 00602 CAFETERI A 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 00900 HOUSEKEEPI NG 00900					1.00 4.00 5.00 6.00 6.01 6.02 7.00 8.00 9.00
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 INPATI ENT ROUTI NE SERVI CE COST CENTERS	93, 848 C C C	732, 210 8, 374	101 0	100	10. 00 13. 00 14. 00 15. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF	50, 918 9, 494 02 8, 029	48, 480 0 31, 169	11 5 0 1 0	0 0 0 0 0	30.00 31.00 40.00 41.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS		33, 304	0	0	42.00 43.00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC 57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY 60.01 0KOCLOGY 60.02 06002 RADIATION 0NCOLOGY 64.00 INTRAVENOUS THERAPY		96, 072 0 0 0 0 0 23, 220 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21 0 1 0 6 6 1 0 0	0 0 0 0 0 0 0 0 0	50.00 51.00 54.00 57.00 58.00 59.00 60.00 60.01 60.01 60.02 64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 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 00TPATI ENT SERVI CE COST CENTERS		38, 997 23, 253 35, 678 5, 048 0 0 0 0	203	0 0 0 0 0 0 100	65.00 66.00 69.00 69.01 71.00 72.00 73.00
90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0THER REI MBURSABLE COST CENTERS	C 3, 533 C	116, 045		0 0 0	90. 00 91. 00 92. 00 92. 01
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	С	49, 261	0	0	
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	- <u>-</u>	1		100	113. 00 118. 00
190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PACT REV PHYSI CI ANS 192. 02 19202 VI SI TOR MEALS 192. 03 19203 GREAT BEGI NNI NGS/MATERNAL 192. 04 19204 LI FELI NE 192. 05 19205 OWNED PROPERTI ES 192. 06 19206 UROLOGY 192. 07 19207 PHYSI CI ANS' PRI VATE OFFI CES 192. 08 19210 PARI SH NURSI NG 192. 09 19212 BI OTERRORI SM GRANT 192. 10 19214 BREAST PUMPS 192. 11 19208 MGH EMERGENCY PHYSI CI ANS 192. 12 19209 LUNG CENTER 192. 12 19210 MGH EXPRESS 192. 13 19213 MGH EXPRESS 192. 14 19210 MGH PHYS PRACT MGMT 192. 15 IGH PHYS PRACT MGMT 192. 16 IP216 MGH MGH MED ONC 192. 17 19217 MGH FAI RM MED ASSOC 192. 19 19218 MGH FAI RM MED ASSOC 192		0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0		190.00 192.00 192.01 192.02 192.03 192.04 192.05 192.06 192.07 192.08 192.09 192.10 192.11 192.12 192.13 192.14 192.15 192.16 192.16 192.18 192.19

Health Finar	ncial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Period: From 07/01/2021	Worksheet B-1
					To 06/30/2022	
	Cost Center Description	DI ETARY	NURSI NG	CENTRAL	PHARMACY	11/30/2022 9:15 am
		(MEALS	ADMI NI STRATI O	SERVICES &	(COSTED	
		SERVED)	N	SUPPLY	REQUIS.)	
			(DI RECT NRSI NG HRS)	(COSTED REQUI S.)		
		10.00	13.00	14.00	15.00	
	NONPAID WORKERS	0			0 0	193.00
	MGH FMC NORTHWOOD	0	0		1 0 1 0	193. 01 193. 02
	MGH HOSPITALISTS	0	0		0 0	193.03
	MGH MAR FAM PRACT	0	0		6 0	193.04
	MGH FMC SWAYZEE MGH PEDIATRIC CTR	0	0		1 0	193.05 193.06
	MGH SPECIALTY PHYS	0	0			193.07
193. 08 19308	MGH FMC CONVERSE	0	0		1 0	193.08
	MGH UPLAND HEALTH MGH MGH WOMENS CTR	0	0			193.09
	MGH MGH WOMENS CTR MGH MGH PSYCHIATRY		0			193. 10 193. 11
193. 12 19312		0	0	1		193.12
	MGH RIVER VIEW BLDG	0	0		0 0	193.15
	MGH NEONATOLOGY MGH WOUND CARE	0	0			193. 16 193. 18
	HEART FAILURE CLINIC	0	0		0 0	194.00
194.0107950		14, 690			0 0	194.01
	MENTAL HEALTH ADVERTI SI NG	7, 184	0			194.02
	MGH WORK SOLUTIONS		0		2 0	194.03 194.04
	MGH TAYLOR UNIVERSITY	0	0		0 0	194.05
	OPIOID IMPL GRANT	0	0		0 0	194.06
	ASTHMA GRANT MGH SMMP BLDG		0			194.07 194.08
	MGH AMBUCARE BLDG	0	0		0 0	194.09
	MGH 106 LYONS BLDG	0	0		0 0	194. 10
194. 11 07960 194. 12 07961		0	0		0 1 0	194. 11 194. 12
194. 13 07969		0	0			194.12
194. 14 07964	WABASH	0	0		0 0	194.14
	TOBACCO GRANT	0	0			194.15
	HRSA NETWORK DEV PLANNING HRSA OPIOID PLANNING		0		0	194.16 194.17
194. 18 07962		0	0		0 0	194.18
	RURAL QI GRANT	0	0		0 0	194.19
	MGH DI ABETES GRANT MGH MGH ORTHO		0			194. 20 194. 21
	MGH BELLA BLDG	0	0		0 0	194. 22
	DI ABETES GRANT	0	0		0 0	194.23
	HEALTH SYS GRANT		0			194. 24 194. 25
200.00	Cross Foot Adjustments	0	0		0	200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	1, 489, 072	1, 849, 485	1, 035, 11	5 5, 655, 361	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	15. 866849	2. 525894	10, 248. 66336	6 56, 553. 610000	203.00
204.00	Cost to be allocated (per Wkst. B,	273, 917				
005 00	Part II)	0.040700	0,000001	4 0/7 70007	0 005 00000	0.05 0.0
205.00	Unit cost multiplier (Wkst. B, Part	2. 918730	0. 090381	1, 067. 79207	9 2, 325. 030000	205.00
206.00	NAHE adjustment amount to be allocated					206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					207.00
2011 00	Parts III and IV)					

Health Fina	incial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/30/2022 9:	pared:
			Title	XVIII	Hospi tal	PPS	
					Costs	110	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		•				
	0 ADULTS & PEDIATRICS	20, 928, 256		20, 928, 25	56 0	20, 928, 256	30.00
	O I NTENSI VE CARE UNI T	7, 604, 548		7,604,54		7,604,548	•
	0 SUBPROVI DER – I PF	0		.,	0 0	0	40.00
	0 SUBPROVI DER – I RF	4,002,252		4, 002, 25	52 0	4,002,252	
	0 SUBPROVI DER	0		.,	0 0	0	42.00
	0 NURSERY	2, 588, 178		2, 588, 1	78 0	2, 588, 178	
	LLARY SERVICE COST CENTERS	_,,			-		
	O OPERATING ROOM	15, 025, 639		15, 025, 63	39 0	15, 025, 639	50.00
	O RECOVERY ROOM	0			0 0	0	51.00
	0 RADI OLOGY-DI AGNOSTI C	8, 246, 915		8, 246, 9 [.]	-	8, 246, 915	
	O CT SCAN	1, 410, 000		1, 410, 00		1, 410, 000	
	O MAGNETIC RESONANCE I MAGING (MRI)	824, 445		824, 44		824, 445	
	O CARDI AC CATHETERI ZATI ON	3, 661, 781		3, 661, 78		3, 661, 781	
	0 LABORATORY	12, 782, 807		12, 782, 80		12, 782, 807	•
	1 ONCOLOGY	2, 203, 613		2, 203, 6		2, 203, 613	
	2 RADIATION ONCOLOGY	2,200,010		2,200,0	0 0	2,200,010	
	O I NTRAVENOUS THERAPY	0			0 0	0	64.00
	0 RESPI RATORY THERAPY	4, 857, 385	0	4, 857, 38	35 0	4, 857, 385	
	O PHYSI CAL THERAPY	3, 904, 561	0	3, 904, 50		3, 904, 561	
	0 ELECTROCARDI OLOGY	2, 524, 355	0	2, 524, 3		2, 524, 355	
	1 CARDI AC REHAB	539, 367		539, 30		539, 367	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	037, 307		557, 50	0 0	0	
	O IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	O DRUGS CHARGED TO PATIENTS	19, 975, 303		19, 975, 30		19, 975, 303	
	ATIENT SERVICE COST CENTERS	17, 775, 505		17, 773, 30		17, 775, 505	/ 5.00
		1, 692, 844		1, 692, 84	14 0	1, 692, 844	90.00
	0 EMERGENCY	13, 885, 494		13, 885, 49		13, 885, 494	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	5, 397, 429		5, 397, 42		5, 397, 429	
	1 OBSERVATION BEDS (DISTINCT PART)	0, 377, 427		5, 577, 42	0 0	0, 377, 429	
	R REIMBURSABLE COST CENTERS	0			0 0	0	72.01
	O AMBULANCE SERVICES	2, 782, 542	1	2, 782, 54	12 0	2, 782, 542	95.00
	I AL PURPOSE COST CENTERS	2,702,342		2,702,54	+2 0	2, 702, 342	95.00
	OINTEREST EXPENSE		1	1	1		113.00
200.00	Subtotal (see instructions)	134, 837, 714	0	134, 837, 7 [.]	14 0	134, 837, 714	
200.00	Less Observation Beds	5, 397, 429		5, 397, 42		5, 397, 429	
201.00	Total (see instructions)	129, 440, 285				5, 397, 429	
202.00		127, 440, 203	1 0	127, 440, 20	ы, ор	127, 440, 203	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	MARION GENERA	Provider CO	CN: 15-0011	In Lieu of Form CMS-255 Period: Worksheet C		
				From 07/01/2021	Part I	
				To 06/30/2022	Date/Time Pre	epared:
			XVIII	Hospi tal	11/30/2022 9: PPS	15 am
		Charges	XVIII	Hospital	PP5	
Cost Center Description	Inpatient		Tatal (aal	6 Cost or Other	TEFRA	
Cost center Description	Inpatient	Outpati ent	+ col. 7)	Ratio	Inpatient	
			+ COL. 7)	Ratio	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	16, 360, 960		16, 360, 96	0		30.00
31. 00 03100 INTENSIVE CARE UNIT	8, 281, 986		8, 281, 98			31.00
	0, 201, 900					40.00
	-			0		40.00
	3, 699, 223		3, 699, 22	.3		
42. 00 04200 SUBPROVI DER	0 500 470		0 500 47	0		42.00
43.00 04300 NURSERY	2, 533, 479		2, 533, 47	9		43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM		00 541 501	119, 320, 49	0. 125927	0,000000	50.00
	28, 778, 992	90, 541, 501			0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 0.000000	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 137, 673	29, 703, 237	31, 840, 91		0.00000	
57.00 05700 CT SCAN	6, 238, 264	37, 747, 398	43, 985, 66		0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	249, 758	3, 546, 290	3, 796, 04		0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 123, 358	7, 259, 249	11, 382, 60		0.00000	
60. 00 06000 LABORATORY	4,017,647	17, 218, 837	21, 236, 48		0.00000	
60. 01 06001 0NC0L0GY	42, 901	6, 145, 191	6, 188, 09		0.00000	
60. 02 06002 RADIATION ONCOLOGY	0	0		0 0.000000	0.00000	
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0. 000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	2, 404, 503	6, 994, 803	9, 399, 30		0.00000	
66. 00 06600 PHYSI CAL THERAPY	4, 598, 167	5, 740, 519	10, 338, 68		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	4, 067, 556	10, 145, 757	14, 213, 31		0. 000000	
69. 01 06901 CARDI AC REHAB	1,000	889, 691	890, 69		0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	13, 266, 287	82, 570, 761	95, 837, 04	.8 0. 208430	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLI NI C	3, 000	2, 563, 158			0. 000000	
91.00 09100 EMERGENCY	13, 814, 686	77, 814, 184	91, 628, 87		0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	12, 395, 206	12, 395, 20		0. 000000	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0. 000000	0. 000000	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	4, 974, 530	4, 974, 53	0 0. 559358	0. 000000	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	114, 619, 440	396, 250, 312	510, 869, 75	2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	114, 619, 440	396, 250, 312	510, 869, 75	2		202.00

Health Financial Systems	MARI ON GENERAL	HOSPI TAL	In Lieu	」of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prep 11/30/2022 9:	pared: 15 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVI DER - I PF					40.00
41.00 04100 SUBPROVIDER - IRF					41.00
42.00 04200 SUBPROVI DER					42.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 125927				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 259004				54.00
57. 00 05700 CT SCAN	0. 032056				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 217185				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 321700				59.00
60. 00 06000 LABORATORY	0. 601927				60.00
60. 01 06001 DNC0L0GY	0. 356105				60.00 60.01
	0. 338105				
					60.02
64.00 06400 I NTRAVENOUS THERAPY	0.000000				64.00
65.00 06500 RESPIRATORY THERAPY	0. 516781				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 377665				66.00
69.00 06900 ELECTROCARDI OLOGY	0. 177605				69.00
69. 01 06901 CARDI AC REHAB	0. 605560				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 208430				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 659680				90.00
91.00 09100 EMERGENCY	0. 151541				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 435445				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0. 559358				95.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1 I			ľ	

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 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/30/2022 9:	epared: 15 am
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	20, 928, 256		20, 928, 2	56 0	20, 928, 256	30.00
	O INTENSIVE CARE UNIT	7, 604, 548		7,604,5	48 0	7, 604, 548	31.00
	0 SUBPROVI DER – I PF	0			0 0	0	
	0 SUBPROVI DER – I RF	4,002,252		4,002,2	52 0	4, 002, 252	
	0 SUBPROVI DER	0			0 0	0	
	0 NURSERY	2, 588, 178		2, 588, 1	78 0	2, 588, 178	43.00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	15, 025, 639		15, 025, 6	39 0	15, 025, 639	50.00
51.00 0510	O RECOVERY ROOM	0			0 0	0	51.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	8, 246, 915		8, 246, 9	15 0	8, 246, 915	54.00
	O CT SCAN	1, 410, 000		1, 410, 0	0 00	1, 410, 000	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	824, 445		824, 4	45 0	824, 445	58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	3, 661, 781		3, 661, 7	81 0	3, 661, 781	59.00
60.00 0600	0 LABORATORY	12, 782, 807		12, 782, 8	0 07	12, 782, 807	60.00
60.01 0600	1 ONCOLOGY	2, 203, 613		2, 203, 6	13 0	2, 203, 613	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, 857, 385	0	4, 857, 3	85 0	4, 857, 385	65.00
66.00 0660	O PHYSI CAL THERAPY	3, 904, 561	0	3, 904, 5	61 0	3, 904, 561	66.00
69.00 0690	0 ELECTROCARDI OLOGY	2, 524, 355		2, 524, 3	55 0	2, 524, 355	69.00
69.01 0690	1 CARDI AC REHAB	539, 367		539, 3	67 0	539, 367	69.01
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	19, 975, 303		19, 975, 3	03 0	19, 975, 303	73.00
OUTP	ATIENT SERVICE COST CENTERS						
	O CLINIC	1, 692, 844		1, 692, 8	44 0	1, 692, 844	90.00
91.00 0910	OEMERGENCY	13, 885, 494		13, 885, 4		13, 885, 494	
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	5, 397, 429		5, 397, 4	29	5, 397, 429	
	1 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0	92.01
	R REIMBURSABLE COST CENTERS			1			
	O AMBULANCE SERVICES	2, 782, 542		2, 782, 5	42 0	2, 782, 542	95.00
	I AL PURPOSE COST CENTERS					_,, 0 12	1
	OINTEREST EXPENSE						1113.00
200.00	Subtotal (see instructions)	134, 837, 714	0	134, 837, 7	14 0	134, 837, 714	
201.00	Less Observation Beds	5, 397, 429		5, 397, 4		5, 397, 429	
202.00	Total (see instructions)	129, 440, 285					
		,, 200		,		, 200	

Health Financial Systems COMPUTATION OF RATIO OF		MARION GENERA	Provi der CO	CN: 15-0011	In Lieu of Form CMS-25 Period: Worksheet C		2002 1
					From 07/01/2021	Part I	
					To 06/30/2022	Date/Time Pre	epared:
					11/30/2022 9:		15 am
				e XIX	Hospi tal	Cost	-
			Charges		<u> </u>		
Cost Center	Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
		(00	7.00	0.00	0.00	Ratio	
		6.00	7.00	8.00	9.00	10.00	
	SERVICE COST CENTERS	1/ 2/2 2/2		14 040 04	0		
30.00 03000 ADULTS & PE		16, 360, 960		16, 360, 96			30.00
31.00 03100 I NTENSI VE C		8, 281, 986		8, 281, 98	36		31.00
40.00 04000 SUBPROVI DER		0			0		40.00
41.00 04100 SUBPROVI DER	- IRF	3, 699, 223		3, 699, 22	23		41.00
42.00 04200 SUBPROVI DER		0		0 500 45	0		42.00
43.00 04300 NURSERY		2, 533, 479		2, 533, 47	/9		43.00
ANCI LLARY SERVI CE			00 544 504	110 000 10	0 105007		1
50.00 05000 OPERATING R		28, 778, 992	90, 541, 501	119, 320, 49		0.00000	
51.00 05100 RECOVERY R0		0	0		0 0.000000	0.00000	
54.00 05400 RADI OLOGY-D	I AGNOS I I C	2, 137, 673	29, 703, 237	31, 840, 91		0.00000	
57.00 05700 CT SCAN		6, 238, 264	37, 747, 398	43, 985, 66		0.00000	
	SONANCE IMAGING (MRI)	249, 758	3, 546, 290	3, 796, 04		0. 000000	
59.00 05900 CARDI AC CATI	HETERI ZATI ON	4, 123, 358	7, 259, 249			0. 000000	
60.00 06000 LABORATORY		4, 017, 647	17, 218, 837	21, 236, 48		0. 000000	
60.01 06001 ONCOLOGY		42, 901	6, 145, 191	6, 188, 09		0. 000000	
60. 02 06002 RADI ATI ON 0		0	0		0 0.000000	0. 000000	
64.00 06400 I NTRAVENOUS		0	0		0 0.000000	0. 000000	
65.00 06500 RESPI RATORY		2, 404, 503	6, 994, 803	9, 399, 30		0. 000000	
66.00 06600 PHYSI CAL TH		4, 598, 167	5, 740, 519	10, 338, 68		0. 000000	
69.00 06900 ELECTROCARD		4, 067, 556	10, 145, 757	14, 213, 31		0. 000000	
69.01 06901 CARDI AC REH		1, 000	889, 691	890, 69		0. 000000	
	PLIES CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	
	CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	
73.00 07300 DRUGS CHARG		13, 266, 287	82, 570, 761	95, 837, 04	0. 208430	0.00000	73.00
OUTPATIENT SERVIC	E COST CENTERS	· · · · · ·			- 1		
90. 00 09000 CLI NI C		3, 000	2, 563, 158			0. 000000	
91.00 09100 EMERGENCY		13, 814, 686	77, 814, 184	91, 628, 87		0. 000000	
	BEDS (NON-DISTINCT PART)	0	12, 395, 206	12, 395, 20		0. 000000	
	BEDS (DISTINCT PART)	0	0		0 0.000000	0. 000000	92.0
OTHER REI MBURSABL							_
95.00 09500 AMBULANCE S		0	4, 974, 530	4, 974, 53	0. 559358	0. 000000	95.00
SPECIAL PURPOSE C							
113.00 11300 INTEREST EX							113.00
	ee instructions)	114, 619, 440	396, 250, 312	510, 869, 75	52		200.00
201.00 Less Observa							201.00
202.00 Total (see	instructions)	114, 619, 440	396, 250, 312	510, 869, 75	52		202.00

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2	552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prep 11/30/2022 9:1	ared: 5 am
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
	04000 SUBPROVI DER – I PF					40.00
41.00	04100 SUBPROVI DER – I RF					41.00
42.00	04200 SUBPROVI DER					42.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
57.00	05700 CT SCAN	0. 000000				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 000000				60.00
60.01	06001 ONCOLOGY	0. 000000				60.01
	06002 RADIATION ONCOLOGY	0. 000000				60.02
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.00
	06500 RESPI RATORY THERAPY	0. 000000				65.00
	06600 PHYSI CAL THERAPY	0. 000000				66.00
	06900 ELECTROCARDI OLOGY	0. 000000				69.00
	06901 CARDI AC REHAB	0. 000000				69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73.00	OUTPATIENT SERVICE COST CENTERS	0.000000				73.00
90.00	09000 CLINIC	0. 000000				90.00
	09100 EMERGENCY	0. 000000				90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				91.00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				
92.01	OTHER REIMBURSABLE COST CENTERS	0.000000				92.01
05 00	09500 AMBULANCE SERVICES	0,000000				05 00
95.00		0. 000000				95.00
112 00	SPECIAL PURPOSE COST CENTERS	1				112 00
	11300 INTEREST EXPENSE					113.00
200.00						200.00
201.00						201.00
202.00	Total (see instructions)				2	202.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPI TAL COSTS	Provider C		Period: From 07/01/2021	Worksheet D Part I	
				To 06/30/2022	Date/Time Pre	
					11/30/2022 9:	<u>15 am</u>
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTE						
30. 00 ADULTS & PEDIATRICS	2, 128, 462	0	2, 128, 462	2 16, 960	125.50	
31.00 INTENSIVE CARE UNIT	584, 025		584, 025	5 4, 197	139.15	31.00
40.00 SUBPROVIDER - IPF	0	0	(0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	450, 330	0	450, 330	2, 719	165.62	41.00
42.00 SUBPROVI DER	0	0	(0 0	0.00	42.00
43.00 NURSERY	59, 286		59, 280	5 1, 509	39.29	43.00
200.00 Total (lines 30 through 199)	3, 222, 103		3, 222, 103	3 25, 385		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
	3 5	Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30.00 ADULTS & PEDIATRICS	4, 425	555, 338				30.00
31.00 INTENSIVE CARE UNIT	783	108, 954				31.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	1, 479	244, 952				41.00
42. 00 SUBPROVI DER	0	211,702				42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	6, 687	909, 244				200.00
200.00 10 tal (11103 00 thi bugh 177)	0,007	707, 244	I			200.00

Health Financial Systems	MARION GENERA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022	11/30/2022 9:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 562, 366	119, 320, 493			82, 089	
51.00 05100 RECOVERY ROOM	0	-	0.00000		0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	913, 039					
57.00 05700 CT SCAN	86, 220					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	80, 277					
59. 00 05900 CARDI AC CATHETERI ZATI ON	261, 411	11, 382, 607	0. 02296	6 1, 184, 507	27, 203	59.00
60. 00 06000 LABORATORY	783, 352	21, 236, 484			50, 849	60.00
60. 01 06001 0NC0L0GY	46, 804	6, 188, 092			34	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	346, 215	9, 399, 306	0. 03683	645, 079	23, 761	65.00
66. 00 06600 PHYSI CAL THERAPY	331, 721	10, 338, 686	0. 03208	35 715, 965	22, 972	66.00
69. 00 06900 ELECTROCARDI OLOGY	341, 780	14, 213, 313	0. 02404	6 1, 700, 476	40, 890	69.00
69. 01 06901 CARDI AC REHAB	60, 207	890, 691	0.06759	6 624	42	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	508, 715	95, 837, 048	0.00530	3, 814, 914	20, 250	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	208, 694	2, 566, 158	0. 08132	2, 257	184	90.00
91.00 09100 EMERGENCY	763, 213	91, 628, 870	0. 00832	4, 850, 981	40, 404	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	548, 935	12, 395, 206	0. 04428	6 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, 842, 949	475, 019, 574		24, 256, 145	338, 519	200.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COS		-	Period: From 07/01/2021 Fo 06/30/2022	Worksheet D Part III Date/Time Pre 11/30/2022 9:	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDIATRICS	0	C) (0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	C		0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	C C		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	C C		0 0	0	42.00
43. 00 04300 NURSERY	0	l c		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	l c		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
'	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C	16, 960	0.00	4, 425	30.00
31.00 03100 INTENSIVE CARE UNIT		C	4, 19	7 0.00		
40. 00 04000 SUBPROVIDER - IPF	0	C C			0	40.00
41.00 04100 SUBPROVIDER - IRF	0	l c	2,71	9 0.00	1, 479	41.00
42. 00 04200 SUBPROVI DER	0	l c		0.00	0	42.00
43.00 04300 NURSERY		l c	1,504	9 0.00	0	43.00
200.00 Total (lines 30 through 199)		l c				200.00
Cost Center Description	I npati ent		1			
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00 04000 SUBPROVI DER – I PF	0					40.00
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
200.00 Total (lines 30 through 199)	0					200.00
· · · · · · · · · · · · · · · · · · ·		I.				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CN: 15-0011 Period: From 07/01/2021 To 06/30/2022 To 06/30/2022 Worksheet D Part IV Date/Time Prepared: 10/20/2022 9:15 am	Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Non Physician Anesthetist Cost Nursing Program Adjustments Nursing Program Adjustments Allied Health Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 24 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 50.00 05000 (PEPATI NG ROOM 0 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROM 0 0 0 0 0 51.00 54.00 05400 RADIOLOGV-DIAGNOSTI C 0 0 0 0 0 0 51.00 57.00 05500 CT SCAN 0		RVICE OTHER PAS	S Provider CO	CN: 15-0011	From 07/01/2021	Part IV Date/Time Pre	
Anesthetist Cost Program Post-Stepdown Adjustments Program Adjustments Program Adjustments 50.00 05000 OPERATING ROOM 0			Title	XVIII			
Cost Post-Stepdown Adjustments Adjustments Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 51.00 05100 RECOVERY ROM 0	Cost Center Description		Nursi ng	Nursi ng		Allied Health	
Adj ustments Adj ustments Adj ustments Adj ustments 1.00 2A 2.00 3A 3.00 50.00 05000 0PERATI NG ROOM 0		Anesthetist	Program	Program	Post-Stepdown		
I. 00 2A 2. 00 3A 3. 00 ANCI LLARY SERVICE COST CENTERS		Cost			Adjustments		
ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 0							
50.00 05000 0PERATI NG ROM 0 <td></td> <td>1.00</td> <td>2A</td> <td>2.00</td> <td>3A</td> <td>3.00</td> <td></td>		1.00	2A	2.00	3A	3.00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.01 06000 LABORATORY 0 0 0 0 60.01 60.02 06001 NCOLOGY 0 0 0 0 60.01 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 67.00 <							
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 57.00 57.00 05700 CT SCAN 0 0 0 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 06000 LABORATORY 0 0 0 0 60.00 60.01 0NCOLOGY 0 0 0 0 0 0 60.01 60.02 26002 RADI ATI ON ONCOLOGY 0 0 0 0 0 60.02 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 64.00 06900 ELECTROCARDI OLOGY 0 0 0 0 67.00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td></td></t<>		0	0		0 0	0	
57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 59.00 CARDIAC CATHETERIZATION 0 0 0 0 0 59.00 60.00 CABORATORY 0 0 0 0 0 60.00 60.01 OKOLOGY 0 0 0 0 0 60.01 60.02 ABORATORY 0 0 0 0 0 60.01 60.02 OACOLOGY 0		0	0		0 0	0	
58.00 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.00 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 60.01 OKCOLOGY 0		0	0		0 0	0	
59.00 05900 CARDI AC CATHETERI ZATI ON 0		0	0		0 0	0	
60.00 06000 LABORATORY 0		0	0		0 0	0	
60.01 06001 0NC0L0GY 0		0	0		0 0	0	59.00
60.02 06002 RADI ATI ON ONCOLOGY 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td></td></td<>		0	0		0 0	0	
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 66.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 69.01 06901 CARDI AC REHAB 0 0 0 0 69.01 71.00 07100 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 011741 ENT SERVICE COST CENTERS 0 0 0 0 0 73.00 0200 ORSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 90.00 92.00 92.00 92.00 92.00 92.01 92.00	60. 01 06001 0NC0L0GY	0	0		0 0	0	60.01
65.00 06500 RESPI RATORY THERAPY 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 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 0171.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 02001 MELS COST CENTERS 0 0 0 0 0 90.00 92.00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.01 92.01 92.01 92.00 92.01 92.01 92.01 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>60.02</td>		0	0		0 0	0	60.02
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69.00 69.01 06900 CARDI AC REHAB 0 0 0 0 0 69.01 71.00 O7100 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 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 73.00 90.00 09000 CLINIC 0 0 0 0 90.00 92.00 09200 BESERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 92.01 09200 DESERVATI ON BEDS (DI STI NCT PART) 0 0 0 92.01 07100 00 <td< td=""><td>64.00 06400 INTRAVENOUS THERAPY</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>64.00</td></td<>	64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
69.00 06900 ELECTROCARDIOLOGY 0 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 SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 73.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09000 CLINIC 0 0 0 91.00 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 0THER REIMBURSABLE COST CENTERS 0 0 0		0	0		0 0	0	65.00
69.01 06901 CARDI AC REHAB 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>66.00</td>		0	0		0 0	0	66.00
71.00 07100 MEDI 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 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 73.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 91.00 92.00 92.00 92.01 92.01 92.01 92.01 92.01 92.00 92.00 92.00 92.01 0 0 0 0 92.01 92.01 09201 DBSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.01 92.01 92.01 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 92.01	69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 73.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 90.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01	69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 90.00 92.00 92.00 92.01 92.00 92.01 92.00 92.01	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT_PART) 0 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DI STI NCT_PART) 0 0 0 92.01 92.01 OTHER_REI MBURSABLE_COST_CENTERS 0 0 0 0 92.01	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
90.00 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 0 92.01 07.01 07.02 085.02 07.03 0 0 0 92.01		0	0		0 0	0	73.00
91.00 09100 EMERGENCY 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.01 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92. 00 92. 00 92. 01 92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 92. 01 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 92. 01	90. 00 09000 CLINIC	0	0		0 0	0	90.00
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 OTHER REIMBURSABLE COST CENTERS	91.00 09100 EMERGENCY	0	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS	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
	95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199) 0 0 0 0 0 0 0 200.00	200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
				To 06/30/2022	Date/Time Pre 11/30/2022 9:	pared: 15 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1	<u> </u>	0.00000	
50. 00 05000 OPERATING ROOM	0	0		0 119, 320, 493		
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 31, 840, 910		54.00
57. 00 05700 CT SCAN	0	0		0 43, 985, 662		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 3, 796, 048		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 11, 382, 607		
60. 00 06000 LABORATORY	0	0		0 21, 236, 484		
60. 01 06001 ONCOLOGY	0	0		0 6, 188, 092		
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0.000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 9, 399, 306		65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 10, 338, 686		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 14, 213, 313		69.00
69. 01 06901 CARDI AC REHAB	0	0		0 890, 691	0.000000	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 05 007 040	0.000000	
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0		0 95, 837, 048	0.000000	73.00
90. 00 09000 CLINIC	0	0		0 2, 566, 158	0.000000	90.00
91. 00 09100 EMERGENCY	0			0 91, 628, 870		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 12, 395, 206		92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 12,070,200	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS			1	- 0	0.00000	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 475, 019, 574		200.00
			•			•

Health Financial Systems	MARI ON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/30/2022 9:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	-	Costs (col.	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	6, 269, 202		0 15, 396, 605	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	767, 872		0 6, 253, 130	0	54.00
57.00 05700 CT SCAN	0. 000000	2, 811, 948		0 7, 432, 840	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	109, 254		0 892, 774	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 184, 507		0 2, 468, 899	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 378, 511		0 1, 615, 855	0	60.00
60. 01 06001 ONCOLOGY	0.000000	4, 555		0 2, 076, 871	0	60.01
60. 02 06002 RADIATION 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	645, 079		0 1, 593, 088	0	65.00
66.00 06600 PHYSI CAL THERAPY	0.000000	715, 965		0 38, 185	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0.000000	1, 700, 476		0 2, 240, 345	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	624		0 266, 712	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	3, 814, 914		0 29, 137, 304	0	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
90. 00 09000 CLINIC	0.000000	2, 257		0 811, 778	0	90.00
91.00 09100 EMERGENCY	0,000000	4, 850, 981		0 11, 270, 699	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 1, 535, 334	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)		24, 256, 145		0 83, 030, 419	0	200.00
,	1 1		I		-	

	ncial Systems	MARION GENER	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
					From 07/01/2021 To 06/30/2022	Part V Date/Time Pre	narod.
					10 00/ 30/ 2022	11/30/2022 9:	
			Title	xviii	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9	0.00	(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS	0 125027	15 204 405	1	0 0	1 020 040	50.00
		0. 125927				1, 938, 848	•
	RECOVERY ROOM	0. 000000			0 0	0	51.00
	D RADI OLOGY-DI AGNOSTI C CT SCAN	0. 259004			0 0	1, 619, 586	
		0. 032056 0. 217185			0 0	238, 267	57.00 58.00
	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0. 217185			0 0	193, 897 794, 245	
	LABORATORY	0. 321700				972, 627	60.00
	I ONCOLOGY	0. 356105		1, 90	0 0	739, 584	60.00
	2 RADIATION ONCOLOGY	0. 000000			0 0	/39, 564	60.01
	INTRAVENOUS THERAPY	0. 000000			0 0	0	64.00
	RESPIRATORY THERAPY	0. 516781			0 0	823, 278	
	PHYSICAL THERAPY	0. 377665			0 0	14, 421	66.00
	ELECTROCARDI OLOGY	0. 177605			0 0	397, 896	
	I CARDI AC REHAB	0. 605560				161, 510	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0. 000000			0 0	0	72.00
	D DRUGS CHARGED TO PATIENTS	0. 208430			0 10, 493	6, 073, 088	•
	ATIENT SERVICE COST CENTERS	0.200100	27,107,001	1	10, 170	0,010,000	/ 0. 00
		0. 659680	811, 778		0 0	535, 514	90.00
	EMERGENCY	0. 151541			0 0	1, 707, 973	
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 435445			0 0	668, 554	92.00
	OBSERVATION BEDS (DISTINCT PART)	0. 000000			0 0	0	92.01
	REIMBURSABLE COST CENTERS				· · · · ·		
95.00 09500	AMBULANCE SERVICES	0. 559358			0		95.00
200.00	Subtotal (see instructions)		83, 030, 419	1, 98	0 10, 493	16, 879, 288	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		83, 030, 419	1, 98	0 10, 493	16, 879, 288	202.00

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pro 11/30/2022 9	epared: 15 am
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				51.00
57. 00 05700 CT SCAN	0	0				54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				57.00
59. 00 05900 CARDIAC CATHETERIZATION	0	0				59.00
60. 00 06000 LABORATORY	1, 192	0				60.00
60. 01 06001 ONCOLOGY	1, 172	0				60.00
60. 02 06002 RADIATION ONCOLOGY	0	0				60.02
64. 00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 187				73.00
OUTPATIENT SERVICE COST CENTERS		2,10,				
90. 00 09000 CLI NI C	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0				92.01
OTHER REIMBURSABLE COST CENTERS		-				
95.00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	1, 192	2, 187				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1, 192	2, 187				202.00

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period:	Worksheet D	
		Component	CCN: 15-T011	From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	naradi
		component	CCN. 15-1011	10 00/30/2022	11/30/2022 9:	15 am
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)	0.00			5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1 5 (0 0 ((110 000 100	0.0100	10 105	100	
50. 00 05000 OPERATING ROOM	1, 562, 366					
51.00 05100 RECOVERY ROOM	0	-	0.0000		0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	913, 039				1, 164	54.00
57. 00 05700 CT SCAN	86, 220					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	80, 277					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	261, 411					59.00
60. 00 06000 LABORATORY	783, 352					60.00
60. 01 06001 0NC0L0GY	46, 804	6, 188, 092			0	60. 01
60. 02 06002 RADI ATI ON ONCOLOGY	0	0	0.0000		0	60. 02
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	346, 215				1, 012	65.00
66.00 06600 PHYSI CAL THERAPY	331, 721	10, 338, 686				66.00
69.00 06900 ELECTROCARDI OLOGY	341, 780				631	69.00
69. 01 06901 CARDI AC REHAB	60, 207	890, 691			0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	508, 715	95, 837, 048	0.00530	08 196, 014	1, 040	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	208, 694	2, 566, 158			8	90.00
91. 00 09100 EMERGENCY	763, 213	91, 628, 870			414	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	12, 395, 206			0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.0000	00 0	0	92.01
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	6, 294, 014	475, 019, 574		2, 164, 133	60, 915	200.00

Health Financial Systems	MARION GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C	Provider CCN: 15-0011		Worksheet D D21 Part IV		
THROUGH COSTS		Comment	Component CCN: 15-T011		Part IV		
		Component	JCN: 15-1011	To 06/30/2022	Date/Time Pre 11/30/2022 9:		
		Title	XVIII	Subprovider -	PPS		
				I RF			
Cost Center Description	Non Physician		Nursi ng		Allied Health		
	Anesthetist	Program	Program	Post-Stepdown			
	Cost	Post-Stepdown		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	-	50.00	
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00	
57.00 05700 CT SCAN	0	0		0 0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00	
60. 00 06000 LABORATORY	0	0		0 0	0	60.00	
60. 01 06001 0NC0L0GY	0	0		0 0	0	60.01	
60. 02 06002 RADI ATI ON ONCOLOGY	0	0		0 0	0	60.02	
64.00 06400 INTRAVENOUS 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		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		0 0	0	200. 00	

Health Financial Systems	MARI ON GENERA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS			Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021		
		•		To 06/30/2022	Date/Time Pre 11/30/2022 9:	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum o		(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 119, 320, 493		
51.00 05100 RECOVERY ROOM	0	0		0 0	01000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 31, 840, 910		
57.00 05700 CT SCAN	0	0		0 43, 985, 662		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 3, 796, 048	0. 000000	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 11, 382, 607	0. 000000	59.00
60. 00 06000 LABORATORY	0	0		0 21, 236, 484	0. 000000	60.00
60. 01 06001 ONCOLOGY	0	0		0 6, 188, 092	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 9, 399, 306	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 338, 686	0. 000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 14, 213, 313	0. 000000	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 890, 691	0. 000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 95, 837, 048	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 2, 566, 158	0.000000	90.00
91.00 09100 EMERGENCY	0	0		0 91, 628, 870	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 12, 395, 206	0. 000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	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		0 475, 019, 574		200.00
					•	•

Health Financial Systems	MARION GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	5 Provider C	CN: 15-0011	Peri od:	Worksheet D	
THROUGH COSTS		Composit		From 07/01/2021	Part IV	
		Component	CCN: 15-T011	To 06/30/2022	Date/Time Pre 11/30/2022 9:	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	10, 135		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	40, 577		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	62, 923		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	6, 690		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 212		0 0	0	59.00
60.00 06000 LABORATORY	0. 000000	68, 675		0 0	0	60.00
60. 01 06001 ONCOLOGY	0. 000000	0	1	0 0	0	60.01
60. 02 06002 RADIATION 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	27, 471		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	1, 670, 436		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	26, 253		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	196, 014		0 0	0	73.00
OUTPATI ENT SERVI CE COST CENTERS				-		
90. 00 09000 CLINIC	0,000000	93		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	49, 654		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				<u> </u>		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		2, 164, 133		0 0	0	200.00
	· ·			-	-	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period:	Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	pare
		Title XVIII	Hospi tal	11/30/2022 9: PPS	15 ;
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs excluding newborn)		16, 960	1 1
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing			16, 960	
00	Private room days (excluding swing-bed and observation bed d		orivate room days,	0	3
~~	do not complete this line.			10 50/	
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	12, 586 0	
	reporting period			0	
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om davs) through December	or 31 of the cost	0	7
50	reporting period	on days) through becember	a si oi the cost	0	'
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Dreamon (avaludin	a owing bod and	4, 425	9
50	newborn days) (see instructions)		ig swiftg-bed and	4, 425	7
00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10
00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year,		room uays) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or X		ite room days)	0	12
~~	through December 31 of the cost reporting period			0	1.1
00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
00	Medically necessary private room days applicable to the Prog			0	14
00	Total nursery days (title V or XIX only)		-	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	1 17
	reporting period	C			
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through December 31 c	of the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructio	nc)		20, 928, 256	21
. 00	Swing-bed cost applicable to SNF type services through Decem		ting period (line		
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24
	7 x line 19)	·	0, ,		
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportir	ng period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		20, 928, 256	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation had a	(harges)	0	28
	Private room charges (excluding swing-bed charges)		nai ges)	0	29
	Semi -private room charges (excluding swing bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ictions)	0.00	
00	Average per diem private room cost differential (line 34 x l	ine 31)		0.00	35
00	Private room cost differential adjustment (line 3 x line 35)		lifferential (1)	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	urrerential (line	20, 928, 256	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
<i></i>	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
	Adjusted general inpatient routine service cost per diem (se			1,233.98	
. 00 . 00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog			5, 460, 362 0	
	Total Program general inpatient routine service cost (line 3	. ,		5, 460, 362	1 '

	Financial Systems	MARION GENERA		011 45 0044		u of Form CMS-: Worksheet D-1		
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	Provi der CCN: 15-0011 Peri od: From 07/01/2021 To 06/30/2022			pared: 15 am	
			Title	XVIII	Hospi tal	PPS		
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x		
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00		
42.00	NURSERY (title V & XIX only)	0	0				42.00	
	Intensive Care Type Inpatient Hospital Units	7, 604, 548	4, 197	1, 811. 90				
43.00 44.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	783	1, 418, 718	44.00				
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00 46.00	
	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description			1	Į.			
						1.00		
48.00 49.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			anc)		4, 752, 559	•	
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	uns)		11, 631, 639	49.00	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	664, 292	50.00	
F1 00								
51.00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (f	rom Wkst. D, su	um of Parts II	338, 519	51.00	
52.00	Total Program excludable cost (sum of lines	50 and 51)				1, 002, 811	52.00	
53.00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anesthe	etist, and	10, 628, 828	53.00	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-	
54.00	Program di scharges					0	54.00	
	Target amount per discharge					0.00	•	
56.00	Target amount (line 54 x line 55)					0	•	
57.00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus l	ine 53)	0		
	58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th							
57.00	ipounded by the	0.00	59.00					
60.00	Lesser of lines 53/54 or 55 from prior year					0.00		
61.00	If line 53/54 is less than the lower of line					0	61.00	
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (Tines 54 x	60), or 1% or	the target			
62.00	Relief payment (see instructions)					0	62.00	
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00	
(1 00	PROGRAM INPATIENT ROUTINE SWING BED COST			++! -		0		
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mper 31 of th	e cost reportin	ig period (see	0	64.00	
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00	
	instructions)(title XVIII only)							
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVIII	only). For	0	66.00	
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost rep	porting period	0	67.00	
	(line 12 x line 19)							
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repor	rting period	0	68.00	
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.00	
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY				
70.00	Skilled nursing facility/other nursing facil	2		• • •			70.00	
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ iine	2)			71.00	
73.00	Medically necessary private room cost applic		(line 14 x l	ine 35)			73.00	
74.00	Total Program general inpatient routine serv	•		·			74.00	
75.00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B, Pa	art II, column		75.00	
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00	
77.00	Program capital-related costs (line 9 x line						77.00	
78.00	Inpatient routine service cost (line 74 minu	,					78.00	
79.00	Aggregate charges to beneficiaries for exces	· · ·		,			79.00 80.00	
80.00 81.00	5							
82.00								
83.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in	see instruction	· .				82.00 83.00	
84.00		84.00 85.00						
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)								
00.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						86.00	
87.00	Total observation bed days (see instructions)				4, 374	•	
88.00	Adjusted general inpatient routine cost per		line 2)			1, 233. 98	•	
07. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				5, 397, 429	09.00	

Health Financial Systems	AL HOSPITAL	HOSPITAL In Lie			u of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/30/2022 9:	pared: 15 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 128, 462	20, 928, 256	0. 10170	3 5, 397, 429	548, 935	90.00
91.00 Nursing Program cost	0	20, 928, 256	0.00000	0 5, 397, 429	0	91.00
92.00 Allied health cost	0	20, 928, 256	0.00000	0 5, 397, 429	0	92.00
93.00 All other Medical Education	0	20, 928, 256	0.00000	0 5, 397, 429	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1	
		Component CCN: 15-T011	To 06/30/2022 Subprovi der -	Date/Time Pre 11/30/2022 9: PPS	
	Cost Center Description		I RF	FFJ	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		2, 719	1 1
00	Inpatient days (including private room days, excluding swing-			2, 719	
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	rivate room days,	0	3
	do not complete this line.				
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	2, 719 0	
50	reporting period	on days) thi dugh becenb	er si or the cost	0	
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	- .			
00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m dave) after Decomber	21 of the cost	0	8
50	reporting period (if calendar year, enter 0 on this line)	in days) after becenber	ST OF THE COST	0	
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	1, 479	9
	newborn days) (see instructions)				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room dave) oftor	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
. 00 . 00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	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
. 00	reporting period			0.00	'
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19
~~	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	s)		4, 002, 252	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	1, 002, 202	
	5 x line 17)		51 (
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
00	x line 18) Swing had east applicable to NE type carviace through Decembe	r 21 of the east report	ing pariod (line	0	24
. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	a 31 of the cost report	ing period (inte	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)	•			
. 00	Total swing-bed cost (see instructions)	(11		0	
. 00	General inpatient routine service cost net of swing-bed cost	(IINE 21 minus line 26)		4, 002, 252	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)	a and observation bed t		0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nue line 23) (coo instru	ctions)	0.00	
00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	4, 002, 252	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTNENTC			
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		I	1 /71 04	38
	Adjusted general inpatient routine service cost per diem (see	-		1, 471. 96	
	Program general inpatient routine service cost (line 9 x line	: 38)	1	2. 177 (179)	1.24
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			2, 177, 029 0	

	Financial Systems TATION OF INPATIENT OPERATING COST	MARION GENERAL		CN: 15-0011	In Lie Period:	worksheet D-1		
				CCN: 15-T011	From 07/01/2021 To 06/30/2022	Date/Time Pre	epared:	
			Title	e XVIII	Subprovider -	11/30/2022 9: PPS	15 am	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	5 5	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0 0	42.00	
43.00	I NTENSI VE CARE UNI T	0	С	0.	00 0	0		
44.00 45.00	CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T						44.00	
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description					1.00		
	Program inpatient ancillary service cost (Wk					756, 435		
49.00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructi	ons)		2, 933, 464	49.00	
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (fro	m Wkst. D, sı	um of Parts I and	244, 952	50.00	
51.00	<pre>III) Pass through costs applicable to Program inp.</pre>	ationt ancillary	sorvicos (f	rom Wkst D	sum of Parts II	60.015	51.00	
51.00	and IV)	attent and that y	Services (1	TOIN WKSt. D,	Sum OF Parts IT	00, 915	51.00	
52.00	Total Program excludable cost (sum of lines					305, 867		
53.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line 1		ated, non-pn	ysician anest	inetist, and	2, 627, 597	53.00	
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 55.00	Program di scharges Target amount per di scharge					0.00		
56.00	Target amount (line 54 x line 55)					0		
57.00 58.00	5 1 1 5 5 ()							
59.00								
	market basket							
60.00 61.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00		
	which operating costs (line 53) are less that	n expected costs						
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Docom	bor 21 of th	o cost roport	ting pariod (Saa	0	64.00	
04.00	instructions)(title XVIII only)	ts through becen		e cost repor	ting period (see		04.00	
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the	cost reportin	ng period (See	0	65.00	
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line	65)(title XVI	II only). For	0	66.00	
(7.00	CAH (see instructions)	a agata through	December 21	of the east i	-		67.00	
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost i	eporting period	0	67.00	
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost rep	porting period	0	68.00	
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (l	ine 67 + lin	e 68)		0	69.00	
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY	7)			
70.00 71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	2			()		70.00	
72.00	Program routine service cost (line 9 x line	71)					72.00	
73.00 74.00	Medically necessary private room cost application Total Program general inpatient routine serv	0	•				73.00	
75.00	Capital -related cost allocated to inpatient 26, line 45)	•			Part II, column		75.00	
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00	
77.00	Program capital - related costs (line 9 x line						77.00	
78.00 79.00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		ovider recor	ds)			78.00	
80.00	Total Program routine service costs for compa	arison to the co			nus line 79)		80.00	
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81.00	
83.00	Reasonable inpatient routine service costs (,					83.00	
84.00	Program inpatient ancillary services (see in						84.00	
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85.00 86.00	
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				1		
87.00	Total observation bed days (see instructions					0		
88.00	Adjusted general inpatient routine cost per						88.00	

Health Financial Systems MARION GENERAL HOSPITAL					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
			CCN: 15-T011	To 06/30/2022	Date/Time Pre 11/30/2022 9:	pared: 15 am
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				, í	instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	450, 330	4,002,252	0. 1125	19 0	0	90.00
91.00 Nursing Program cost	0	4,002,252	0.0000	0 0	0	91.00
92.00 Allied health cost	0	4,002,252	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	4, 002, 252	0.0000	0 0	0	93.00

	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST MARION GENERAL	Provider CCN: 15-0011	Period: From 07/01/2021	u of Form CMS-2 Worksheet D-1	
			To 06/30/2022	Date/Time Pre 11/30/2022 9:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing			16, 960 16, 960	
00	Private room days (excluding private room days, excluding swing- private room days (excluding swing-bed and observation bed days)		orivate room days,	10, 900	
	do not complete this line.				
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	12, 586 0	
50	reporting period	com days) thi odgi beceme		0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om davs) through Decembe	er 31 of the cost	0	5
	reporting period			-	
00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable	to the Program (excludir	ng swing-bed and	716	9
	newborn days) (see instructions)		5 5	_	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	1
00	December 31 of the cost reporting period (if calendar year, e			0	1.
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	ix only (including priva	ite room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	1:
. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
. 00	Total nursery days (title V or XIX only)	ram (excluding swing-bed	uays)	1, 509	
	Nursery days (title V or XIX only)				10
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	1 1-
. 00	reporting period	ces through becember 51	of the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	of the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
00	reporting period	>		20,020,254	1 21
. 00 .	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	20, 928, 256	
	5 x line 17)	·	51 .	Ũ	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
	7 x line 19)	·	0, ,		
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	ng period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		20, 928, 256	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed o	charges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	Line 28)		0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IINE 20)		0.000000	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		icti ons)	0.00	
	Private room cost differential adjustment (line 3 x line 35)	1110 31)		0. 00 0	35
	General inpatient routine service cost net of swing-bed cost	and private room cost c	lifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 233. 98	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			883, 530 0	
). 00	IMPOLIATE DECESSARY DELVALE FOOD COST ADDITCADLE TO THE PROD	Law LLINE 14 X LLNE 35)		()	

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	MARI ON GENERA	Provider C	CN: 15-0011 P	eriod:	u of Form CMS-: Worksheet D-1	
				F	rom 07/01/2021 o 06/30/2022	Date/Time Pre	epare
				e XIX	Hospi tal	11/30/2022 9: Cost	15 ar
	Cost Center Description	Total I npati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
2.00	NURSERY (title V & XIX only)	2, 588, 178	1, 509	1, 715. 16			42.
	Intensive Care Type Inpatient Hospital Units	· · · ·					
. 00	I NTENSI VE CARE UNI T	7, 604, 548	4, 197	1, 811. 90	0	0	
. 00	CORONARY CARE UNIT						44.
. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.
. 00	Cost Center Description						47.
	·					1.00	<u> </u>
. 00	Program inpatient ancillary service cost (Wk					411, 204	
. 00	Total Program inpatient costs (sum of lines -	41 through 48)(see instructi	ons)		1, 294, 734	49.
00	PASS THROUGH COST ADJUSTMENTS			What D arm	ef Dente I en		1 50
. 00	Pass through costs applicable to Program inp.	atient routine	services (rro	n WKST. D, SUM	or Parts I and	0	50.
. 00	Pass through costs applicable to Program inp	atient ancillar	v services (fi	om Wkst D si	m of Parts II	0	51.
. 55	and IV)		J 00. 11 003 (11	D, 30			"
2.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.
3.00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anesth	etist, and	0	53.
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	5	5 .		,	0	58
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, i	updated and com	mpounded by the	0.00	59
~~	market basket						
0. 00	Lesser of lines 53/54 or 55 from prior year				the amount by	0.00	
. 00	If line 53/54 is less than the lower of line: which operating costs (line 53) are less that					0	61
	amount (line 56), otherwise enter zero (see		3 (11103 04 X		the target		
	Relief payment (see instructions)					0	62.
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST						1
1.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	rost reporting	neriod (See	0	65.
	instructions)(title XVIII only)			boot i opoi ting	poi i ou (000	0	
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	55)(title XVII	l only). For	0	66.
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs after D	locombor 21 of	the cost rope	rting poriod	0	68.
5.00	(line 13 x line 20)		ecember 31 01	the cost repo	ting period	0	00.
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY			
). 00	Skilled nursing facility/other nursing facil						70.
. 00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v li	ne 35)			72
. 00	Total Program general inpatient routine serv	0	•				74
. 00	Capital-related cost allocated to inpatient				art II, column		75
	26, line 45)			,			1
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00	Program capital -related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces		rovider rocor	te)			78
00	Total Program routine service costs for compa	• •			us line 79)		80
. 00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I)				82
. 00	Reasonable inpatient routine service costs (see instruction					83
. 00	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					4, 374	87
		/				4, 5/4	1
7.00 3.00	Adjusted general inpatient routine cost per	, diem (line 27 ÷	line 2)			1, 233. 98	88

Health Financial Systems	MARION GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/30/2022 9:	pared: 15 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 128, 462	20, 928, 256	0. 10170	3 5, 397, 429	548, 935	90.00
91.00 Nursing Program cost	0	20, 928, 256	0.00000	0 5, 397, 429	0	91.00
92.00 Allied health cost	0	20, 928, 256	0.00000	0 5, 397, 429	0	92.00
93.00 All other Medical Education	0	20, 928, 256	0.00000	0 5, 397, 429	0	93.00

OMPUT	Financial Systems MARION GENERAL ATION OF INPATIENT OPERATING COST	HOSPITAL Provider CCN: 15-0011	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T011	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/30/2022 9:	pare
		Title XIX	Subprovider -	Cost	15 0
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1100	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			2, 719	1.
00	Inpatient days (including private room days, excluding swing			2, 719	2
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). It you nave only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation I	bed days)		2, 719	4
00	Total swing-bed SNF type inpatient days (including private re		er 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 dava) through Decembe	n 21 of the east	0	7
00	Total swing-bed NF type inpatient days (including private roo reporting period	on days) through becembe	I SI UI LINE CUSL	0	'
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	25	9
). 00	newborn days) (see instructions)	only (including private	room dave)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, o		i com dago, ar cor	Ũ	
2.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Prog			0	14
. 00	Total nursery days (title V or XIX only)	Tam (excluding swing-bed	uays)	1, 509	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17
	reporting period	after December 21 af	++	0.00	10
3. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period			4 000 050	0.1
. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ting pariod (ling	4, 002, 252 0	
2.00	5 x line 17)	bei 31 01 the cost repor	ting period (inte	0	22
3.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)		5 T X		
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
	7 x line 19)			0	0
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25
5.00	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 002, 252	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	
00	Private room charges (excluding swing-bed charges)			0	
. 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	itterential (line	4,002,252	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			ł
. 00	Adjusted general inpatient routine service cost per diem (see			1, 471. 96	38
	Program general inpatient routine service cost (line 9 x line			36, 799	
	Medically necessary private room cost applicable to the Prog			0	
. 00	Total Program general inpatient routine service cost (line 34	9 + line 40)		36, 799	1 41

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	MARION GENERA		CN: 15-0011	In Lie Period:	worksheet D-1	
			CCN: 15-T011	From 07/01/2021 To 06/30/2022	Date/Time Pre	epare
		Ti t	e XIX	Subprovider -	11/30/2022 9: Cost	:15 a
				I RF		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00) 42.
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni		(0.0	0 0		<u> </u>
3. 00 I NTENSI VE CARE UNI T	0	(0.0	0 0	C	
1. OO CORONARY CARE UNIT 5. OO BURN INTENSIVE CARE UNIT						44.
5. 00 SURGICAL INTENSIVE CARE UNIT						46.
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
3.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3	, line 200)			11, 166	5 48.
0.00 Total Program inpatient costs (sum of line	es 41 through 48)(see instructi	ons)		47,965	5 49.
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program i	innatient routine	services (fro	m Wkst D su	m of Parts I and	d C	50.
			m wkst. D, Su		Ĭ	00.
.00 Pass through costs applicable to Program i	inpatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	C	51.
and IV) .00 Total Program excludable cost (sum of line	es 50 and 51)				c c	52
3.00 Total Program inpatient operating cost ex		lated, non-ph	ysician anest	hetist, and	C C	
medical education costs (line 49 minus lin	ne 52)					-
TARGET AMOUNT AND LIMIT COMPUTATION 1.00 Program discharges					C	54
.00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)				1	C	
.00 Difference between adjusted inpatient oper .00 Bonus payment (see instructions)	rating cost and ta	rget anount (inne so minus	TThe 53)		
00 Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and c	ompounded by the	-	59
market basket					0.00	
0.00 Lesser of lines 53/54 or 55 from prior yea 1.00 If line 53/54 is less than the lower of li					0.00	
which operating costs (line 53) are less						
amount (line 56), otherwise enter zero (se	ee instructions)					
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive pa	avment (see instru	ctions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						
4.00 Medicare swing-bed SNF inpatient routine (costs through Dece	mber 31 of th	e cost report	ing period (See	C	64.
instructions)(title XVIII only) 5.00 Medicare swing-bed SNF inpatient routine of	costs after Decemb	er 31 of the	cost reportin	a period (See	c c	65.
instructions)(title XVIII only)			·			
 D. 00 Total Medicare swing-bed SNF inpatient row CAH (see instructions) 	utine costs (line	64 plus line	65)(title XVI	II only). For	C	66
7.00 Title V or XIX swing-bed NF inpatient rou	tine costs through	December 31	of the cost r	eporting period	c	67.
(line 12 x line 19)	Ū.					
3.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	tine costs after D	ecember 31 of	the cost rep	orting period	C) 68.
9.00 Total title V or XIX swing-bed NF inpatie	nt routine costs (line 67 + lir	ie 68)		c c	69.
PART III - SKILLED NURSING FACILITY, OTHER	R NURSING FACILITY	, AND ICF/IID	ONLY		1	
 0.00 Skilled nursing facility/other nursing facility/ot)		70.
2.00 Program routine service cost (line 9 x lin		ine 70 ÷ ine	2)			72.
8.00 Medically necessary private room cost app	0	•	,			73.
4.00 Total Program general inpatient routine so	•			Dort II column		74.
 Capital-related cost allocated to inpatien 26, line 45) 	int routine service	CUSIS (IIUM	WUINSHEEL B,	rart II, COLUMN		75.
b. 00 Per diem capital-related costs (line 75 \div						76.
.00 Program capital-related costs (line 9 x li .00 Inpatient routine service cost (line 74 mi						77
8.00 Inpatient routine service cost (line 74 mi 9.00 Aggregate charges to beneficiaries for exe	,	rovi der recor	ds)			79.
.00 Total Program routine service costs for co	omparison to the c			nus line 79)		80
.00 Inpatient routine service cost per diem li		`				81.
 2.00 Inpatient routine service cost limitation 3.00 Reasonable inpatient routine service costs 	•					82.
4.00 Program inpatient ancillary services (see	•	- /				84.
5.00 Utilization review - physician compensation						85.
5.00 Total Program inpatient operating costs (PART IV - COMPUTATION OF OBSERVATION BED F		rougn 85)				86.
7.00 Total observation bed days (see instruction					C	87.
3.00 Adjusted general inpatient routine cost po	•	line 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)	(see instructions)				I C) 89.

Health Financial Systems	MARION GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
		Component (To 06/30/2022	Date/Time Pre 11/30/2022 9:	pared: 15 am
		Ti tl	e XIX	Subprovider -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	450, 330	4, 002, 252	0. 1125	19 0	0	90.00
91.00 Nursing Program cost	0	4, 002, 252	0.0000	0 0	0	91.00
92.00 Allied health cost	0	4, 002, 252	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	4, 002, 252	0.0000	0 0	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	3
			From 07/01/2021		
			To 06/30/2022	Date/Time Pre 11/30/2022 9:	epared:
	Title	XVIII	Hospi tal	PPS	
Cost Center Description	II LI C	Ratio of Cos		Inpatient	
COST CENTER DESCRIPTION		To Charges		Program Costs	
		10 charges	U U	(col. 1 x	
			Charges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS			5, 578, 579		30.00
31. 00 03100 I NTENSI VE CARE UNI T			1, 806, 480		31.00
40. 00 04000 SUBPROVI DER - I PF			1, 000, 400		40.00
40. 00 04000 SUBPROVI DER - I RF			2 710		40.00
			2, 710		
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0 1250	27 (260 202	700 440	50.00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM		0. 1259 0. 0000		789, 462	
				0	
54.00 O5400 RADI OLOGY-DI AGNOSTI C		0.2590		198, 882	
57.00 05700 CT SCAN		0.0320		90, 140	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2171		23, 728	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 3217		381, 056	
60. 00 06000 LABORATORY		0. 6019		829, 763	
60. 01 06001 0NC0L0GY		0. 3561			
60. 02 06002 RADI ATI ON ONCOLOGY		0.0000		0	
64. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 5167		333, 365	
66. 00 06600 PHYSI CAL THERAPY		0. 3776		270, 395	
69. 00 06900 ELECTROCARDI OLOGY		0. 1776		302, 013	69.00
69. 01 06901 CARDI AC REHAB		0.6055	60 624	378	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	00 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000	00 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2084	30 3, 814, 914	795, 143	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 6596	80 2, 257	1, 489	90.00
91. 00 09100 EMERGENCY		0. 1515	41 4, 850, 981	735, 123	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4354	45 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000		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)			24, 256, 145	4, 752, 559	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			24, 256, 145		202.00

Health Financial Systems MARION GENERAL H		01 45 0014		eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Period: From 07/01/202	Worksheet D-3	3
	Component	CCN: 15-T011	To 06/30/202	2 Date/Time Pre	
	Title	XVIII	Subprovider -	11/30/2022 9: PPS	15 am
	ii tie		IRF	115	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	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 SUBPROVI DER – I PF					40.00
41. 00 04100 SUBPROVI DER – I RF			2, 027, 96	1	41.00
42. 00 04200 SUBPROVI DER			2,027,70	1	42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1259:	27 10, 13	5 1, 276	50.00
51.00 05100 RECOVERY ROOM		0.0000	00	o c	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2590	04 40, 57	7 10, 510	54.00
57. 00 05700 CT SCAN		0. 0320		3 2, 017	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2171			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 32170			
60. 00 06000 LABORATORY		0. 60192			
60. 01 06001 0NCOLOGY		0. 35610		o C	
60. 02 06002 RADIATION ONCOLOGY		0.0000		0 0	
64. 00 06400 I NTRAVENOUS THERAPY		0.0000		0 0	
		0. 5167			
66.00 O6600 PHYSI CAL THERAPY		0.3776			
69. 00 06900 ELECTROCARDI 0LOGY 69. 01 06901 CARDI AC_REHAB		0. 1776 0. 6055		3 4,663 0 0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 20843		-	
OUTPATIENT SERVICE COST CENTERS		0.2001	170,01	10,000	/ /0.00
90. 00 09000 CLINIC		0. 6596	80 9	3 61	90.00
91.00 09100 EMERGENCY		0. 1515			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4354		0 0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	00	o c	92.01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 164, 13	3 756, 435	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0	201.00
202.00 Net charges (line 200 minus line 201)			2, 164, 13	3	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCR: 15-0011 Period: From 07/01/2021 To 06/30/2022 Worksheet D-3 Date/Time Program Cost Center Description Title XIX Hospital To Charges Title XIX Hospital Program Date/Time Program Date/Time Date/Time Program Date/Time Date/Time Program Date/Time Date/Time Program Date/Time Date/Time Program Date/Time Date/Time Program Date/Time Date/Time Program Date/Time Program Date/Time Program	Health Financial Systems MARION GENE	RAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
To 06/30/2022 Date/Time Prepared: 11/2022 P: 15 am Cost Center Description Title XIX Hospital Cost To Charges To Charges Cost Inpatient Program Charges Program Costs (col 1 x col 2) 0.00 03000(ADULTS & PEDIATRICS 1.00 2.00 3.00 30.00 03000(ADULTS & PEDIATRICS 765,896 30.00 1.00 04100 SUBPROVIDER - IPF 276,165 31.00 1.00 04300 NURSERV 0 41.00 42.00 0.010 040000 SUBPROVIDER - IRF 0 42.00 42.00 0.010 04000 Cost Centrers 0 43.00 0.125927 1,004,913 126,546 50.00 0.00500 OPERATINE ROOM 0.125927 1,004,913 126,546 50.00 51.00	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0011	Peri od:	Worksheet D-3	
Intervention Title XIX Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges 0.00 03000 ADULTS & PEDI ATRICS 1.00 2.00 3.00 1.00 03000 ADULTS & PEDI ATRICS 765,896 30.00 0.00 03000 ADULTS & PEDI ATRICS 765,896 30.00 1.00 2200 UNTERSI VE CARE UNI T 276,165 31.00 0.00 04000 SUBPROVI DER - 1 RF 0 41.00 42.00 04200 SUBPROVI DER - 1 RF 0 43.00 30.00 051.00 05100 (PECATINE ROOM 0.125927 1.004,913 126,546 50.00 51.00 0500 (PECATINE ROOM 0.3259004 60.783 15,743 54.00 59.00 0500 (ARDIAL CATHETER ZATION 0.321700 28.879 9.290 59.00 60.00 060000 0.000000 0 0.6802 60.0733 15,743 54.00 59.00 05000 (ARDIAL CATHETER ZAT					Data /Tima Dra	norod.
Title XIX Hospital Cost Cost Center Description Ratio Cost To Charges Inpatient Program Program Program Cost 0.00 03000 Autor 2.00 3.00 3.00 0.00 03000 NUTS PEDIATRICS 30.00 30.00 0.00 03000 NUTS PEDIATRICS 765.896 30.00 0.00 03000 NUTS PEDIATRICS 0 40.00 0.00 03000 NUTS PEDIATRICS 30.00 40.00 0.00 04000 SUBPROVIDER - 1PF 0 0 41.00 41.00 0.01 04000 SUBPROVIDER 1.00 2.00 30.00 43.00 0.00 04000 SUBPROVIDER 1.01 0.125927 1.004.913 126,546 50.00 0.00 05000 PERMITE ROUTIAN CONTRES 0 153.743 54.00 0.00 05000 CROMADIC LARY SERVICE 0.259004 0.321700 28.879 9				10 06/30/2022		
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program (harges) Inpatient Program (harges) 30.00 03000 (ADULTS & PEDLATRICS 30.00 3.00 3.00 3.00 31.00 03000 (NULTS & PEDLATRICS 30.00 765,896 31.00 30.00 31.00 03100 (INTENSIVE CARE UNIT 0.00 276,165 31.00 40.00 41.00 04100 SUBPRVIDER - 1 PF 0 40.00 40.00 42.00 04200 SUBPRVIDER - 1 RF 0 44.00 44.00 43.00 04000 CUBPRVIDER - 1 RF 0 45.00 45.00 50.00 05000 (PECOVERY ROOM 0.125927 1.004,913 126,546 50.00 51.00 05100 (FECOVERY ROOM 0.32056 4.67 57.00 51.00 54.00 05400 (ARDI LGGY-DI AGNOSTIC 0.321700 28,879 9.290 59.00 59.00 05600 (ARDI LGGY-DATHETERIZATION 0.321700 28,879 9.290 59.00 60.00 0.000000 0 0 66.022 60.00 60.0		Ti †I	e XIX	Hospi tal		
INPATI ENT ROUTINE SERVICE COST CENTERS To Charges Program Costs (col. 12) Program Costs (col. 2) 30.00 03000 AUUTS & PEDIATR CS 765,896 30.00 30.00 1.00 2.00 3.00 30.00 001175 & PEDIATR CS 765,896 30.00 40.00 UNENSIVE CARE UNIT 276,165 31.00 30.00 04000 SUBPROVIDER - 1PF 0 42.00 43.00 04300 OPERATING ROM 0.12527 1,004,913 126,546 50.00 05000 OPERATING ROM 0.125297 1,004,913 126,546 50.00 51.00 05100 RECOVERY ROM 0.125297 1,004,913 126,546 50.00 51.00 0500 RADIOLOGY-DI ANOSTIC 0.289004 60,783 15.743 54.00 51.00 0500 MARETIC RESONANCE I MAGING (MRI) 0.217185 1,611 355 50.00 59.00 05000 LABORATORY 0.601927 110,980 66,802 60.00 60.01 06000 LABORATORY 0.37665 32,574 12,302 66.00	Cost Center Description					
Impart ENT ROUTINE SERVICE COST CENTERS Col. 2) 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 276, 186 31.00 40.00 04000 SUBBROVI DER - 1 PF 276, 185 31.00 41.00 04100 SUBBROVI DER - 1 PF 0 41.00 42.00 04200 SUBBROVI DER - 1 PF 0 42.00 ANCILLARY SERVICE COST CENTERS 0 43.00 50.00 05000 OPECANTING ROOM 0.000000 0 51.00 51.00 05100 OR ECOVERY ROOM 0.023026 126, 867 4.067 55.00 51.00 05000 OPECANTING ROOM 0.023026 126, 867 4.067 55.00 52.00 05000 MAGNETIC RESONANCE I MAGING (MRI) 0.217185 1.611 356.80 58.00 05000 MAGNETIC RESONANCE I MAGING (MRI) 0.217185 1.660.82 60.00 60.01 06000 LABORATORY 0.000000 0 0 64.00 65.00 61.02 060000 LABORATORY 0.351675 1						
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42.00 DUBPROVI DER 0 42.00 DUBPROVI DER 0 42.00 Constraints 42.00 Constraints 42.00 43.0	40. 00 04000 SUBPROVIDER - IPF			0		40.00
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58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.217185 1,611 350 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.321700 28.879 9,290 59.00 60.00 LABORATORY 0.601927 110,980 66.802 60.00 60.01 0KOOLLOGY 0.356105 168 66.00 60.01 60.02 06002 RADIATION ONCOLOGY 0.000000 0 64.00 60.02 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 64.00 65.00 06500 RSEPI RATORY THERAPY 0.516781 79,646 41,160 65.00 65.00 06400 PHYSI CAL THERAPY 0.377665 32,574 12,302 66.00 69.01 06400 CARDIA C REHAB 0.605560 0 0 0 71.00 69.01 77.87 12,039 69.00 72.00 73.00 0.3000 0 0 71.00 77.965 74.207 77.965 74.207 77.965 74.207 77.966 74.207 72.00 73.00 0.0000000 </td <td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td> <td></td> <td>0. 25900</td> <td>60, 783</td> <td>15, 743</td> <td>54.00</td>	54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25900	60, 783	15, 743	54.00
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59.00 05900 CARDI AC CATHETERI ZATI ON 0.321700 28,879 9,290 59.00 60.00 06000 LABORATORY 0.601927 110,980 66,802 60.01 60.01 06001 NCOLOGY 0.355105 168 60 60.01 64.00 06000 INTRAVENOUS THERAPY 0.000000 0 64.00 65.00 RESPI RATORY THERAPY 0.516781 79,646 41,160 65.00 66.00 06000 LECTROCARDI OLOGY 0.177605 67,787 12,302 66.00 69.00 06900 ELECTROCARDI OLOGY 0.177605 67,787 12,039 69.00 69.01 06901 CARDI AC REHAB 0.605560 0 0 71.00 71.00 DOSOL CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.208430 374,207 77,96 73.00 90.00 09100 EMERGENCY 0.151541 295,956 44,849 91.00 92.01 09201 DBSERVATI ON BEDS (INON-DI STI NC	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 21718	35 1, 611	350	58.00
60.01 06001 0NCOLOGY 0.356105 168 60 60.01 60.02 06002 RADI ATLON ONCOLOGY 0.000000 0 60.02 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.377665 32,574 12,032 66.00 69.00 06900 ELECTROCARDI OLOGY 0.177605 67,787 12,039 69.00 69.01 06901 CARDI AC REHAB 0.605560 0 0 69.01 71.00 OTIO0 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.208430 374,207 77,996 73.00 01.00 09000 CLINIC 0.659680 0 0 90.00 92.01 91.00 D9200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0.435445 0 0 92.00 92.00 92.01 09200 DESERVATI ON BEDS (DI STI NCT PART) 0.000000 0 92.01 92.01 92.01 92.01 </td <td>59. 00 05900 CARDI AC CATHETERI ZATI ON</td> <td></td> <td>0. 32170</td> <td></td> <td>9, 290</td> <td>59.00</td>	59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 32170		9, 290	59.00
60.01 06001 0NCOLOGY 0.356105 168 60 60.01 60.02 06002 RADI ATLON ONCOLOGY 0.000000 0 60.02 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.377665 32,574 12,032 66.00 69.00 06900 ELECTROCARDI OLOGY 0.177605 67,787 12,039 69.00 69.01 06901 CARDI AC REHAB 0.605560 0 0 69.01 71.00 OTIO0 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.208430 374,207 77,996 73.00 01.00 09000 CLINIC 0.659680 0 0 90.00 92.01 91.00 D9200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0.435445 0 0 92.00 92.00 92.01 09200 DESERVATI ON BEDS (DI STI NCT PART) 0.000000 0 92.01 92.01 92.01 92.01 </td <td>60. 00 06000 LABORATORY</td> <td></td> <td>0, 60192</td> <td>110, 980</td> <td>66, 802</td> <td>60.00</td>	60. 00 06000 LABORATORY		0, 60192	110, 980	66, 802	60.00
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69.01 06901 CARDI AC REHAB 0.605560 0 0 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.208430 374.207 77.996 73.00 07300 DRUGS CHARGED TO PATIENTS 0.208430 374.207 77.996 70.00 09000 CLINIC 0.659680 0 0 90.00 90.00 09000 CLINIC 0.151541 295,956 44,849 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0.435445 0 0 92.00 92.01 09200 DBSERVATION BEDS (DISTINCT PART) 0.000000 0 92.00 92.01 07HER REIMBURSABLE COST CENTERS 0.9500 0 0 92.01						69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.208430 374,207 77,996 00000 CLINIC 0.659680 0 0 90.00 90.00 09100 EMERGENCY 0.151541 295,956 44,849 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.435445 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 92.01 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00 90.00 Unic Laboratory Services-Program only charges (line 61) 0 0 201.00						
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.208430 374,207 77,996 73.00 00100 09000 CLINIC 0.659680 0 0 90.00 90.00 91.00 09200 DEMERGENCY 0.151541 295,956 44,849 91.00 92.01 09200 DBSERVATION BEDS (NON-DI STINCT PART) 0.435445 0 0 92.00 92.01 07HER REI MBURSABLE COST CENTERS 0 0 92.01 0 95.00 950.00 0 95.00 92.01 0 95.00 0 92.01 0 92.01 0 92.01 0 92.00 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0 92.01 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.208430 374,207 77,996 73.00 0UTPATIENT SERVICE COST CENTERS 00000 CLINIC 0.659680 0 0 90.00 90.00 90.00 0151541 295,956 44,849 91.00 92.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.435445 0 0 92.00 92.01 000000 0 92.00 92.01 000000 0 92.00 92.01 000000 0 92.00 92.01 95.00 000000 0 92.01 92.01 95.00 950.00 950.00 9500 MBULANCE SERVICES 95.00 95.00 950.00 2, 184, 371 411, 204 200.00 201.00 2						•
OUTPATI ENT SERVICE COST CENTERS 90.00 OUTPATI ENT SERVICE COST CENTERS 90.00 O9000 CLINIC 0.659680 0 0 90.00 91.00 O9100 EMERGENCY 0.151541 295,956 44,849 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.435445 0 0 92.00 92.01 O9201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 92.01 95.00 OP500 AMBULANCE SERVICES 95.00 950.00 950.00 950.00 20,100 201.00					77.996	
90.00 09000 CLINIC 0.659680 0 0 90.00 91.00 09100 EMERGENCY 0.151541 295,956 44,849 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0.435445 0 0 92.00 92.01 09201 DBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 92.01 92.01 09500 AMBULANCE SERVICES 0 95.00 9500 AMBULANCE SERVICES 95.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 20.00 201.00						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.435445 0 0 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 0 0 92.01 0THER REIMBURSABLE COST CENTERS 0 0 92.00 92.01 95.00 09500 AMBULANCE SERVICES 95.00 2, 184, 371 411, 204 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00			0. 65968	30 0	0	90.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.435445 0 0 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 0 0 92.01 0THER REIMBURSABLE COST CENTERS 0 0 92.00 92.01 95.00 09500 AMBULANCE SERVICES 95.00 2, 184, 371 411, 204 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00	91. 00 09100 EMERGENCY		0. 15154	295, 956	44, 849	91.00
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0.000000 0 92.01 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 201.00 2, 184, 371 411, 204 200.00 201.00 201.00 201.00 0 201.00 201.00 0 201.00 0 201.00 0 201.00 0 201.00 201.00 0 201.00 201.00 0 201.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>1</td></t<>						1
OTHER REI MBURSABLE COST CENTERS95.0009500AMBULANCE SERVICES200.00Total (sum of lines 50 through 94 and 96 through 98)2, 184, 371201.00Less PBP Clinic Laboratory Services-Program only charges (line 61)0						
200.00 Total (sum of lines 50 through 94 and 96 through 98) 2, 184, 371 411, 204 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				!		1
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95. 00 09500 AMBULANCE SERVI CES					95.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	200.00 Total (sum of lines 50 through 94 and 96 through 98))		2, 184, 371	411, 204	200.00
						•
	202.00 Net charges (line 200 minus line 201)			2, 184, 371		202.00

	ncial Systems MAR NCILLARY SERVICE COST APPORTIONMENT	RION GENERAL HOSPITAL	CN: 15-0011	Peri od:	u of Form CMS- Worksheet D-3	
INPALLENT A	NCILLARI SERVICE CUSI APPORTIUNMENT	Provider c	CN. 15-0011	From 07/01/2021	worksheet D-3	2
		Component	CCN: 15-T011	To 06/30/2022	Date/Time Pre	epared:
					11/30/2022 9:	
		Ti tl	e XIX	Subprovider -	Cost	
				I RF		
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2.00	3.00	
	IENT ROUTINE SERVICE COST CENTERS		_		_	
30.00 03000	ADULTS & PEDIATRICS					30.00
31.00 03100	INTENSIVE CARE UNIT					31.00
40.00 04000	SUBPROVIDER - IPF					40.00
	SUBPROVIDER - IRF		1	33, 875		41. OC
	SUBPROVI DER					42.00
	NURSERY					43.00
	LARY SERVICE COST CENTERS		1			- 101.00
	OPERATING ROOM		0. 1259	27 0	0	50.00
	RECOVERY ROOM		0.0000			
	RADI OLOGY-DI AGNOSTI C		0. 2590		-	
	CT SCAN		0. 0320			
	MAGNETIC RESONANCE IMAGING (MRI)		0. 2171			
	CARDIAC CATHETERIZATION		0. 3217		-	
	LABORATORY		0. 6019			
	ONCOLOGY					
	RADIATION ONCOLOGY		0. 3561			
					-	
			0.0000		0	
			0.5167			
	PHYSICAL THERAPY		0.3776			
	ELECTROCARDI OLOGY		0. 1776		0	
	CARDI AC REHAB		0.6055		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
	IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
	DRUGS CHARGED TO PATIENTS		0. 2084	30 3, 360	700	73.00
	TI ENT SERVICE COST CENTERS					_
90.00 09000			0. 6596			
	EMERGENCY		0. 1515		-	
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 4354		0	
92.01 09201	OBSERVATION BEDS (DISTINCT PART)		0.0000	0 00	0	92.01
	REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50 through 94 and 96 th	rough 98)		30, 631	11, 166	200.00
201.00	Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)	5 5 6 6 7 9	1	30, 631	1	202.00

	Financial Systems MARION GENERAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0011	In Lie Period: From 07/01/2021 To 06/30/2022	u of Form CMS-2 Worksheet E Part A Date/Time Pre 11/30/2022 9:	pared:
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		I	_	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to October 1	(see	0 2, 457, 832	
1. 02	DRG amounts other than outlier payments for discharges occurs instructions)	ring on or after October	1 (see	8, 215, 273	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI 1 1 (see instructions)	for discharges occurring	prior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI 1 October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2. 01 2. 02	Outlier reconciliation amount	tions)		0	2.01 2.02
2.02	Outlier payment for discharges for Model 4 BPCI (see instruct Outlier payments for discharges occurring prior to October 1			20, 087	2.02
2.03	Outlier payments for discharges occurring on or after October			49, 450	
3.00	Managed Care Simulated Payments			47,430	3.00
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	orting period (see instr	ructions)	95.82	4.00
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet $^\circ$ 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 ACA § 5503 reduction amount to the IME cap as specified under			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 allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	lots 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 sl under § 5506 of ACA. (see instructions)	lots from a closed teach	ing hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)			0.00	
	FTE count for allopathic and osteopathic programs in the cur	rent year from your reco	ords		10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	
12.00	Current year allowable FTE (see instructions)				
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,	0.00 0.00	
15.00	Sum of lines 12 through 14 divided by 3.			0,00	15.00
	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital clo	osure		0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
	Current year resident to bed ratio (line 18 divided by line 4	4).		0.00000	
	Prior year resident to bed ratio (see instructions)			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			0	22.00 22.01
	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CER 412 105	0.00	
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	
	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or lin	e 24 (see	0.00	
	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions)			0.00000	
	IME add-on adjustment amount (see instructions)	-)		0	
	IME add-on adjustment amount - Managed Care (see instructions	s)		0	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	01)		0	29.00 29.01
30.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instru	ictions)	5.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)			25.73	
	Sum of Lines 30 and 31			31.02	
	Allowable disproportionate share percentage (see instructions	s)		14.81	

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Peri od:	Worksheet E	
		From 07/01/2021 To 06/30/2022		pare
			11/30/2022 9:	15 a
	Title XVIII	Hospi tal	PPS	
		Prior to 10/1 1.00	0n/After 10/1 2.00	
Uncompensated Care Adjustment		1.00	2.00	
5.00 Total uncompensated care amount (see instruction	ns)	8, 290, 014, 521	7, 192, 008, 710	35.
5.01 Factor 3 (see instructions)		0. 000197803		
5.02 Hospital uncompensated care payment (If line 34	is zero, enter zero on this line) (s	see 1, 639, 790	2, 029, 895	35.
instructions)				
5.03 Pro rata share of the hospital uncompensated cal		413, 317		
6.00 Total uncompensated care (sum of columns 1 and 2 Additional payment for high percentage of ESRD b		1, 931, 567		36
0.00 Total Medicare discharges (see instructions)	beneficiary discharges (Times 40 thro	0		40
		Before 1/1	On/After 1/1	40
		1.00	1.01	
1.00 Total ESRD Medicare discharges (see instructions	s)	0	0	41
1.01 Total ESRD Medicare covered and paid discharges		0	0	
2.00 Divide line 41 by line 40 (if less than 10%, you		0.00		42
3.00 Total Medicare ESRD inpatient days (see instruc		0		43
 Ratio of average length of stay to one week (lindays) 	ne 43 divided by line 41 divided by h	0. 000000		44
5.00 Average weekly cost for dialysis treatments (see	e instructions)	0.00	0.00	45
6.00 Total additional payment (line 45 times line 44		0		46
7.00 Subtotal (see instructions)	,	13, 069, 381		47
3.00 Hospital specific payments (to be completed by S	SCH and MDH, small rural hospitals	11, 793, 400		48
only. (see instructions)				
			Amount	
9.00 Total payment for inpatient operating costs (see	e instructions)		1.00 13,069,381	49
D.00 Payment for inpatient program capital (from Wks		<i>;</i>)	810, 687	50
1.00 Exception payment for inpatient program capital			0	51
2.00 Direct graduate medical education payment (from			0	52
3.00 Nursing and Allied Health Managed Care payment			0	53
4.00 Special add-on payments for new technologies			53, 853	
4.01 Islet isolation add-on payment	ad 1 (inc (0))		0	
5.00 Net organ acquisition cost (Wkst. D-4 Pt. III, 6 6.00 Cost of physicians' services in a teaching hospi			0	55
7.00 Routine service other pass through costs (from N	• •	through 35)	0	57
8.00 Ancillary service other pass through costs from		through boy.	0	
9.00 Total (sum of amounts on lines 49 through 58)			13, 933, 921	59
0.00 Primary payer payments			21, 958	60
1.00 Total amount payable for program beneficiaries	(line 59 minus line 60)		13, 911, 963	
2.00 Deductibles billed to program beneficiaries			1, 439, 444	
3.00 Coinsurance billed to program beneficiaries 4.00 Allowable bad debts (see instructions)			9, 246 84, 844	
5.00 Adjusted reimbursable bad debts (see first detroits)	ns)		55, 149	
5.00 Allowable bad debts for dual eligible beneficial			21, 271	
7.00 Subtotal (line 61 plus line 65 minus lines 62 an			12, 518, 422	
3.00 Credits received from manufacturers for replaced		(see instructions)	0	
9.00 Outlier payments reconciliation (sum of lines 93	3, 95 and 96). (For SCH see instruction	ons)	0	
D. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		· · · · · · · · · · · · · · · · · · ·	0	
0.50 Rural Community Hospital Demonstration Project	· · · · · · · · · · · · · · · · · · ·	e instructions)	0	
D.87 Demonstration payment adjustment amount before s D.88 SCH or MDH volume decrease adjustment (contract			0	
 Be sch of MDH volume decrease adjustment (contract) 89 Pioneer ACO demonstration payment adjustment amount 	57		0	70
 O. 90 [HSP bonus payment HVBP adjustment amount (see in 	, ,		0	
D. 91 HSP bonus payment HRR adjustment amount (see in			0	70
0.92 Bundled Model 1 discount amount (see instruction			0	70
0.93 HVBP payment adjustment amount (see instructions	s)		12, 019	70
or ye miter pagmente augustinente amounte (soos rinstrustrustrust				1
0.94 HRR adjustment amount (see instructions) 0.95 Recovery of accelerated depreciation			-9, 735	70 70

NLUUL	Financial Systems MARION GENERAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPI TAL Provi der C	CN: 15-0011	Peri od:	u of Form CMS-2 Worksheet E	
				From 07/01/2021 To 06/30/2022	Part A Date/Time Pre 11/30/2022 9:	pareo
		Title	e XVIII	Hospi tal	PPS	10 01
		ii ti c		(yyyy)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.
0. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70.
D. 98	Low Volume Payment-3				0	70.
D. 99	HAC adjustment amount (see instructions)				0	70.
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			12, 520, 706	71.
1.01	Sequestration adjustment (see instructions)				31, 302	
1. 02	Demonstration payment adjustment amount after sequestration				0	
1.03	Sequestration adjustment-PARHM pass-throughs					71.
2.00	Interim payments				12, 263, 471	
2.01	Interim payments-PARHM				0	72.
3.00 3.01	Tentative settlement (for contractor use only)				0	73.
4.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			225, 933	
F. UU	73)	02, 72, anu			220, 933	/4.
4.01	Balance due provider/program-PARHM (see instructions)					74.
5.00	Protested amounts (nonallowable cost report items) in accorda	ance with			360, 147	
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90
	plus 2.04 (see instructions)					
. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91
. 00	Operating outlier reconciliation adjustment amount (see instr				0	
. 00	Capital outlier reconciliation adjustment amount (see instruc				0	93
1.00	The rate used to calculate the time value of money (see instr	uctions)			0.00	94.
	5 1				0	05
5.00	Time value of money for operating expenses (see instructions))			0	
5.00 6.00	5 1)		Prior to 10/1	0	
5.00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc)		Prior to 10/1 1.00	0	95. 96.
5.00 5.00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount)		1.00	0 0n/After 10/1 2.00	96.
5.00 5.00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions))			0 0n/After 10/1 2.00	
. 00 . 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment)		1.00	0 0n/After 10/1 2.00 0	96. 100.
. 00 . 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	ctions)		0.000000000	0 0n/After 10/1 2.00 0 0.000000000	96. 100.
. 00 . 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ctions)		1.00	0 0n/After 10/1 2.00 0 0.000000000	96. 100.
. 00 . 00 0. 00 1. 00 2. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	ctions)		0.000000000	0 0n/After 10/1 2.00 0 0.000000000	96 100 101 102
. 00 . 00 0. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		1.00 0 0.000000000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.000000000 0	96 100 101 102 103
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	ns) s) ctions)		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.000000000 0	96 100 101 102 103
0. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment for HSP amonstration project (§410A Demonst Is this the first year of the current 5-year demonstration performance of the current 5-year demonstratio	ns) s) ctions)		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96 100 101 102 103 104
0. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment (see instru	ns) s) ctions)		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96 100 101 102 103 104
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ns) s) ration) Adji		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0	96. 100. 101. 102. 103. 104. 200.
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. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ns) ctions) ns) cration) Adju eriod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 0 0 0	96. 100. 101. 102.
. 00 . 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ns) ctions) ns) cration) Adju eriod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 203.
. 00 . 00 . 00 . 00 . 00 1. 00 2. 00 3. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare di scharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ns) s) ration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203.
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions) 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, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ns) s) ration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 204. 205.
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. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment 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, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare 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)	htions) htions) hs) rration) Adju rration Adju rriod under he 49) h first year htick year htick year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96 100 101 102 103 104 200 201 202 203 204 205 206 206 207 208 209
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ns) ctions) ns) cration) Adju ration Adj	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96 100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ns) ctions) ns) cration) Adju ration Adj	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96 100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
5. 00 5. 00 7. 00 9. 00 0. 00 1. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement) ctions) ctions) ns) cration) Adju eriod under ne 49) n first year h first year h first year h first year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0.000000000 0 0.0000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line) ctions) ctions) ns) cration) Adju eriod under ne 49) n first year h first year h first year h first year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96 100 101 102 103 104 200 201 203 203 204 205 206 205 206 207 208 209 210 211 212
. 00 . 00 . 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	b ctions) ctions) ctions) s) cration) Adju eriod under ne 49) n first year herions) line 59) cructions) line 59)	of the curre	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96 100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211

	Financial Systems DLUME CALCULATION EXHIBIT 4		MARION GENERA		CN: 15-0011	Period: From 07/01/2021 To 06/30/2022		t 4 pare
				T: +1 -	e XVIII	Hochi tal	11/30/2022 9: PPS	15 a
		l i ne	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	0n/After 10/01	Total (Col 2 through 4)	
0.0		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1.
01	DRG amounts other than outlier payments for discharges	1.01	2, 457, 832	C	2, 457, 83	2	2, 457, 832	1.
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	8, 215, 273	0		8, 215, 273	8, 215, 273	1
)3	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1.03	0	C		0	0	1
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after	1.04	0	C		0	0	1
0	October 1 Outlier payments for	2.00						2
01	discharges (see instructions) Outlier payments for	2.02	0	n		0 0	0	2.
	discharges for Model 4 BPCI		_	Ū				
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	20, 087	C	20, 08	7	20, 087	2
3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	49, 450	C		49, 450	49, 450	2
0	Operating outlier reconciliation	2.01	0	0		0 0	0	3
0	Managed care simulated payments	3.00	0	C		0 0	0	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0 0. 000000		5
0	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0 0	0	6
1	instructions) IME payment adjustment for	22. 01	0	O		0 0	0	6
	managed care (see instructions)							
	Indirect Medical Education Adju	ustment for th	e Add-on for Se	ection 422 of	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000	0 0.000000		7
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	C		0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	0	C		0 0	0	9
)1	Total IME payment for managed care (sum of lines 6.01 and	29.01	0	C		0 0	0	9
	8.01) Disproportionate Share Adjustme	ent			1			1
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1481	0. 1481	0. 148	0. 1481		10
00	Disproportionate share	34.00	395, 172	0	91, 00	304, 171	395, 172	11
01	adjustment (see instructions) Uncompensated care payments	36.00	1, 931, 567	0	413, 31	7 1, 518, 250	1, 931, 567	11
00	Additional payment for high per Total ESRD additional payment	<u>Centage of ES</u> 46.00		ui scharges	1	0 0	0	12
	(see instructions)			0				
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	13, 069, 381 0	C C	2, 982, 23	7 10, 087, 144 0 0	13, 069, 381 0	
00	<pre>small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)</pre>	49.00	13, 069, 381	C	2, 982, 23	7 10, 087, 144	13, 069, 381	15

	Financial Systems LUME CALCULATION EXHIBIT 4		MARION GENERA	Provi der C	CN: 15-0011	Peri od: From 07/01/2021	u of Form CMS-2 Worksheet E Part A Exhibi	
						To 06/30/2022	Date/Time Pre 11/30/2022 9:	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50.00	810, 687	0			810, 687	16.0
7.00	if applicable) Special add-on payments for new technologies	54.00	53, 853	0	15, 38	38, 464	53, 853	
7.01 7.02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.0 17.0
18.00	devices for applicable MS-DRGs Capital outlier reconciliation		0	0		0 0	0	18.0
10.00	adjustment amount (see instructions) SUBTOTAL			0	3, 189, 92	22 10, 743, 999	13, 933, 921	10.0
19.00	SUBTUTAL	W/S L, line	(Amounts from L)	0	5, 109, 92	22 10, 743, 999	13, 933, 921	19.0
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	-	793, 795	0			793, 795	20.0
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	16, 892	0	5,49	96 11, 396	16, 892	21.0
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000			0	22.0
23.00	Indirect medical education adjustment (see instructions)	6.00					0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	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	810, 687	0	192, 29	96 618, 391	810, 687	26.0
		W/S E, Part A						
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0.000000	0	27.0 28.0
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. C
100. 00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. C

	Financial Systems TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	MARION GENERA TION EXHIBIT 5			Period: From 07/01/2021	u of Form CMS-2 Worksheet E Part A Exhibi	
					To 06/30/2022		pare
			Title	XVIII	Hospi tal	PPS	15 0
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
			A)				
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00			_		1.
)1	DRG amounts other than outlier payments for	1.01	2, 457, 832	2, 457, 83	2	2, 457, 832	1
~	discharges occurring prior to October 1	1 00	0 045 070		0.015.070	0 015 070	
2	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	8, 215, 273		8, 215, 273	8, 215, 273	1
3	DRG for Federal specific operating payment	1. 03	0		0	0	1
5	for Model 4 BPCI occurring prior to October	1.05	Ŭ		0	0	l .
	1						
4	DRG for Federal specific operating payment	1.04	0		0	0	1
	for Model 4 BPCI occurring on or after						
	October 1						
0	Outlier payments for discharges (see	2.00					2
	instructions)						
1	Outlier payments for discharges for Model 4	2.02	0		0 0	0	2
	BPCI						
2	Outlier payments for discharges occurring	2.03	20, 087	20, 08	7	20, 087	2
~	prior to October 1 (see instructions)	0.04	10 150		10, 150	40.450	
3	Outlier payments for discharges occurring on	2.04	49, 450		49, 450	49, 450	2
0	or after October 1 (see instructions)	2 01	0		o o	0	3
0	Operating outlier reconciliation	2. 01 3. 00	0		0 0 0 0	0	
J	Managed care simulated payments Indirect Medical Education Adjustment	3.00	0		0 0	0	- 1
0	Amount from Worksheet E, Part A, Line 21	21.00	0. 000000	0. 00000	0 0. 000000		1 5
5	(see instructions)	21.00	0.000000	0.00000	0.000000		
0	IME payment adjustment (see instructions)	22.00	0		o o	0	6
1	IME payment adjustment for managed care (see		0		0 0	0	
	i nstructi ons)	22.01	Ū				
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of t	he MMA			1
0	IME payment adjustment factor (see	27.00	0. 000000	0.00000	0 0. 000000		1 7
	instructions)						
0	IME adjustment (see instructions)	28.00	0		0 0	0	8
1	IME payment adjustment add on for managed	28. 01	0		0 0	0	8
	care (see instructions)						
0	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	
1	Total IME payment for managed care (sum of	29.01	0		0 0	0	9
	lines 6.01 and 8.01)						
~~	Disproportionate Share Adjustment		0.4404	0.140	0 1 101		1 4 6
00	1 1 1 5	33.00	0. 1481	0. 148	1 0. 1481		10
00	(see instructions) Disproportionate share adjustment (see	34.00	395, 172	91, 00	1 304, 171	395, 172	11
00	instructions)	34.00	370, 172	91,00	304,171	373, 172	' '
01	Uncompensated care payments	36.00	1, 931, 567	413, 31	7 1, 518, 250	1, 931, 567	11
	Additional payment for high percentage of ESF			110, 01	1, 510, 230	1, 751, 507	1 ''
00	Total ESRD additional payment (see	46.00	0		0 0	0	12
	i nstructi ons)						
00	Subtotal (see instructions)	47.00	13, 069, 381	2, 982, 23	7 10, 087, 144	13, 069, 381	13
00	Hospital specific payments (completed by SCH	48.00	0		0 0	0	14
	and MDH, small rural hospitals only.) (see						
	instructions)						
0C	Total payment for inpatient operating costs	49.00	13, 069, 381	2, 982, 23	7 10, 087, 144	13, 069, 381	15
	(see instructions)						
00	Payment for inpatient program capital (from	50.00	810, 687	192, 29	6 618, 391	810, 687	16
	Wkst. L, Pt. I, if applicable)						
00	Special add-on payments for new technologies	54.00	53, 853	15, 38	9 38, 464	53, 853	
01	Net organ acquisition cost						17
02	Credits received from manufacturers for	68.00	0		0 0	0	17
	replaced devices for applicable MS-DRGs						
	Capital outlier reconciliation adjustment	93.00	0		0 0	0	18
00							
	amount (see instructions) SUBTOTAL			3, 189, 92	2 10, 743, 999	13, 933, 921	

Health Financial Systems HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	MARION GENERA TION EXHIBIT 5			Period: From 07/01/2021 To 06/30/2022		t 5 pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	793, 795	186, 80	0 606, 995	793, 795	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	16, 892	5, 49	6 11, 396	16, 892	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	810, 687	192, 29	6 618, 391	810, 687	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
 27.00 28.00 Low volume adjustment prior to October 1 29.00 Low volume adjustment on or after October 1 30.00 HVBP payment adjustment (see instructions) 30.01 HVBP payment adjustment for HSP bonus 	70. 96 70. 97 70. 93 70. 90	0 0 12, 019 0	12, 01	0 9 0 0 0	0 0 12, 019 0	29.00 30.00
payment (see instructions) 31.00 HRR adjustment (see instructions) 31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-9, 735 0	-3, 95	7 -5,778 0 0		
· · · · · ·					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	, i i i i i i i i i i i i i i i i i i i	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100.00

	Financial Systems MARION GENERAL HO ATION OF REIMBURSEMENT SETTLEMENT P	SPITAL Provider CCN: 15-0011	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
			From 07/01/2021 To 06/30/2022	Part B Date/Time Pre	
		Title XVIII	Hospi tal	11/30/2022 9: PPS	<u>15 am</u>
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 379	
2.00 3.00	Medical and other services reimbursed under OPPS (see instructi OPPS payments	ons)		16, 879, 288 14, 514, 573	
4.00	Outlier payment (see instructions)			184, 522	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	ions)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)			0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV Organ acquisitions	, col. 13, line 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3, 379	1
	COMPUTATION OF LESSER OF COST OR CHARGES				1
12.00	Reasonable charges Ancillary service charges			12, 473	12 00
12.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ie 69)		12,473	
14.00	Total reasonable charges (sum of lines 12 and 13)	, 		12, 473	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for pa	went for convious on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)		5	-	
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 12,473	
18.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 18 exceeds l	ine 11) (see	9,094	
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds l	ine 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			3, 379	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see instru	icti ons)		0 14, 699, 095	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			14, 099, 095	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	-		2, 733, 535 11, 968, 939	
27.00	instructions)	us the sum of times 2		11, 906, 939	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 11, 968, 939	
	Primary payer payments			1, 225	
32.00	Subtotal (line 30 minus line 31)			11, 967, 714	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. 1-5, line 11)	S)		0	33.00
	Allowable bad debts (see instructions)			473, 217	
35.00	Adjusted reimbursable bad debts (see instructions)			307, 591	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	icti ons)		266, 608 12, 275, 305	
38.00	MSP-LCC reconciliation amount from PS&R			12, 273, 303	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			12, 275, 305 30, 688	
40.01	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
41.00 41.01	Interim payments Interim payments_PAPHM			12, 315, 688	41.00
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-71, 071	43.00 43.01
43.01 44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	chapter 1,	0	
	§115. 2		· · · · · · · · · · · · · · · · · · ·		
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
00				0	

Health Financial Systems	MARI ON GENERAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period:	Worksheet E	
		From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
		10 00,00,2022	11/30/2022 9:	15 am
	Title XVIII	Hospi tal	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

ANALY	1 Financial Systems MARION GENER/ SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0011	Period: From 07/01/2021 To 06/30/2022		pared:
			XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		12, 263, 4		12, 315, 688	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		12, 263, 4	/1	12, 315, 688	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	L				
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02 5.03				0	0	5.02 5.03
5.05	Provider to Program			U	0	5.03
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.5
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
4 01	the cost report. (1) SETTLEMENT TO PROVIDER		225 0	22	0	4 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		225, 9	33	71,071	6. 01 6. 02
5.02 7.00	Total Medicare program liability (see instructions)		12, 489, 4	0	12, 244, 617	7.02
			12, 407, 4	Contractor	NPR Date	,
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

ANALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Component	CN: 15-0011 CCN: 15-T011	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Pre 11/30/2022 9:	pared:
		Title	e XVIII	Subprovider - IRF	PPS	
		I npati er	it Part A	Par	tВ	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
. 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 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	1.00	2, 999, 6.		4.00 0 0	
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
. 01 . 02 . 03 . 04 . 05	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0 0	3.02 3.03 3.04
	Provider to Program		1			
. 50 . 51 . 52 . 53 . 54	ADJUSTMENTS TO PROGRAM			0 0 0 0 0	0 0 0 0	3.5 3.5 3.5 3.5 3.5
. 99 . 00	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 999, 6	0 29	0	3.9 4.0
	appropriate) TO BE COMPLETED BY CONTRACTOR		I			
. 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)					5.0
. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.0
5. 02 5. 03				0 0	0 0	
. 50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5.5
. 50 . 51 . 52 . 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.5
. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)				0	6.0
. 01 . 02 . 00	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		67, 6 3, 067, 2	0	0 0 0	
	· · · · · · · · · · · · · · · · · · ·			Contractor Number	NPR Date (Mo/Day/Yr)	

Heal th Financial Systems MARION GENERAL HOSPITAL In Lieu of Form CMS-2552- CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0011 Period: From 07/01/2021 To 06/30/2022 9: 15 ar Worksheet E-1 Date/Time Prepared 11/30/2022 9: 15 ar TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS In Lieu of Form CMS-2552- In Lieu of Form 07/01/2021 To 06/30/2022 9: 15 ar TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS In Lieu of Form CMS-2552- In Lieu of Form 07/01/2021 To 06/30/2022 9: 15 ar In Lieu of Form CMS-2552- Title XVIII Hospital Period: Period: From 07/01/2013 Worksheet E-1 Date/Time Prepared 11/30/2022 9: 15 ar In Lieu of Form CMS-2552- Title XVIII Hospital Period: Period: Worksheet E-1 Date/Time Prepared 11/30/2022 9: 15 ar In Lieu of Form CMS-2552- Title XVIII Hospital Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Period: Title XVIII Hospital Date/Time Prepared 1.00 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. 1, col. 6, sum of lines 1, and 8 through 12, and plus for cost 1.00 1.00 <
1.00 MEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of Lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 8, sum of Lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.1 2.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.1 3.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.0 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.0 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.0 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.0 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.0
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.1 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 2.1 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.1 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.1 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.1 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.1 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.1
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.1 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 2.1 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.1 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.1 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.1 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.1 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.1
 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I
 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168
reporting periods beginning on or after 10/01/2013, line 32) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.1 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 3.0 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.1 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.1 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.1
 4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.0 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.1 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.1 1 ine 168 10 10
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.1 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 7.1
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168
9.00 Calculation of the ULT incentive normant (see instructions)
8.00 Calculation of the HIT incentive payment (see instructions)
9.00 Sequestration adjustment amount (see instructions) 9.1
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH
30.00 Initial/interim HIT payment adjustment (see instructions) 30.0
31.00 Other Adjustment (specify) 31.0
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0011	Period: From 07/01/2021	Worksheet E-3 Part III	
		Component CCN: 15-T011	To 06/30/2022		
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
00	Net Federal PPS Payment (see instructions)			2, 923, 811	1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0335	2
00	Inpatient Rehabilitation LIP Payments (see instructions)			145, 313	3
00	Outlier Payments			36, 439	4
00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period e	naing on or prior	0.00	5
01	Cap increases for the unweighted intern and resident FTE cou	int for residents that we	re displaced by	0.00	5
0.	program or hospital closure, that would not be counted with			01 00	
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth	period of a "new	0.00	
00	teaching program" (see instructions)	the new preason arouth	norted of a "now	0.00	
00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	T the new program growth	period of a new	0.00	8
00	Intern and resident count for IRF PPS medical education adju	ustment (see instructions)	0.00	
00	Average Daily Census (see instructions)		, ,	7.449315	
00	Teaching Adjustment Factor (see instructions)			0.000000	1
. 00	Teaching Adjustment (see instructions)			0	1
00	Total PPS Payment (see instructions)			3, 105, 563	
00	Nursing and Allied Health Managed Care payments (see instruc	ction)		0	1
00	Organ acquisition (DO NOT USE THIS LINE)			0	1
00 00	Cost of physicians' services in a teaching hospital (see ins Subtotal (see instructions)	structions)		0 2 105 542	
00	Primary payer payments			3, 105, 563 0	
00	Subtotal (line 17 less line 18).			3, 105, 563	
00	Deducti bl es			30, 616	
00	Subtotal (line 19 minus line 20)			3, 074, 947	
00	Coinsurance			0	2
00	Subtotal (line 21 minus line 22)			3, 074, 947	2
00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		0	2
. 00	Adjusted reimbursable bad debts (see instructions)			0	2
00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	20
00 00	Subtotal (sum of lines 23 and 25)	Lipo (0)		3, 074, 947 0	2
00	Direct graduate medical education payments (from Wkst. E-4, Other pass through costs (see instructions)	1111e 49)		0	2
00	Outlier payments reconciliation			0	3
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	3
98	Recovery of accelerated depreciation.			0	3
99	Demonstration payment adjustment amount before sequestration	ר		0	
00	Total amount payable to the provider (see instructions)			3, 074, 947	
. 01	Sequestration adjustment (see instructions)			7,687	
02 00	Demonstration payment adjustment amount after sequestration Interim payments			0 2, 999, 629	
00	Tentative settlement (for contractor use only)			2, 777, 027	34
00	Balance due provider/program (line 32 minus lines 32.01, 32.	02, 33, and 34)		67, 631	
00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	chapter 1,	0	36
					1
00	TO BE COMPLETED BY CONTRACTOR		1	04 400	
00	Original outlier amount from Wkst. E-3, Pt. III, line 4			36, 439	
. 00 . 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	5
. 00	Time Value of Money (see instructions)			0.00	
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AM	ND BEGINNING BEFORE THE F	ND OF THE COVID-1		1
		LET THE DEFORE THE E	2 <u>2</u> 00D		99

CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	DSPITAL Provider CCN: 15-0011	Peri od:	Worksheet E-3	2552-10
CALCOL			From 07/01/2021 To 06/30/2022	Part VII	pared:
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
		11 0E0 E00 TITLED 14 00	1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	VICES FOR TITLES V OR	XIX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		1, 294, 734		1.00
2.00	Medical and other services		1, 274, 734	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	-	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 294, 734	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 294, 734	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
8.00	Reasonable Charges Routine service charges		1, 042, 061		8.00
9.00	Ancillary service charges		2, 184, 371	0	9.00
10.00	Organ acquisition charges, net of revenue		2, 101, 0, 1	0	10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		3, 226, 432	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	333	0	13.00
4.4 . 0.0	basi s			0	44.00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		on 0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413.13(e)	0. 000000	0.000000	15 00
16.00	Total customary charges (see instructions)		3, 226, 432	0.000000	
17.00	Excess of customary charges over reasonable cost (complete only	vifline 16 exceeds	1, 931, 698	0	
	line 4) (see instructions)		, ,		
18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds li	ne 0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instru		1 204 724	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 10 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o		1, 294, 734	0	21.00
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	
24.00	Program capital payments		0	-	24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		1, 294, 734	0	29.00
30.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30.00
30.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 294, 734	0	
32.00	Deductibles		1, 294, 734	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1, 294, 734	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
38.00	Subtotal (line 36 ± line 37)		1, 294, 734	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	-	39.00
40.00 41.00	Total amount payable to the provider (sum of lines 38 and 39)		1, 294, 734	0	
41.00	Interim payments		1, 636, 035	0	
	Balance due provider/program (lipe 40 minus lipe 41)				
42.00 43.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	-341, 301 0	0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2021	Worksheet E-3 Part VII	
		To 06/30/2022	Date/Time Pre 11/30/2022 9:		
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	SERVICES FOR TITLES V OR		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		47, 965		1 -
00	Medical and other services				
00	Organ acquisition (certified transplant centers only)				
00	Subtotal (sum of lines 1, 2 and 3)	, , , , , , , , , , , , , , , , , , , ,			
00 00	Inpatient primary payer payments	0	0		
00	Dutpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)			0	
00	COMPUTATION OF LESSER OF COST OR CHARGES	47,965	0	1	
	Reasonabl e Charges				1
00	Routi ne servi ce charges	33, 875		8	
00	Ancillary service charges	30, 631	0		
. 00	Organ acquisition charges, net of revenue	0		1(
. 00	Incentive from target amount computation	0	_	1	
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		64, 506	0	12
. 00	Amount actually collected from patients liable for payment	for services on a charge	0	0	11:
. 00	basis	Tor services on a charge	0	0	'`
. 00	Amounts that would have been realized from patients liable	for payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with			-	
. 00				0.00000	1
. 00	5 5 5			0	
. 00	Excess of customary charges over reasonable cost (complete o	16, 541	0	1	
. 00	line 4) (see instructions)	only if line 4 exceeds li	ne 0	0	18
. 00	Excess of reasonable cost over customary charges (complete of 16) (see instructions)	only IT ITTle 4 exceeds IT	ne u	0	
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		47, 965	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b	be completed for PPS prov			
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		2
. 00 . 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	2
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)	·	47, 965	0	20
	COMPUTATION 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)	47, 965	0	
	Deductibles		0	0	
. 00 . 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	and 33)	47, 965	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	
. 00	Subtotal (line 36 ± line 37)		47, 965	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39
. 00	Total amount payable to the provider (sum of lines 38 and 34	9)	47, 965	0	
. 00	Interim payments		81, 531	0	
. 00	Balance due provider/program (line 40 minus line 41)		-33, 566	0	
3.00	Protested amounts (nonallowable cost report items) in accord chapter 1, §115.2	0	0	43	

	Financial Systems MARION GENERA E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		riod: om 07/01/2021	u of Form CMS-2 Worksheet G Date/Time Pre	pared:
5 <u></u> J)		General Fund	Specific Purpose Fund	Endowment Fund	11/30/2022 9: Plant Fund	<u>15 am</u>
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	38, 780, 794	0	0	0	1.00
2.00	Temporary investments	38, 772, 552		0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00 5.00	Accounts receivable Other receivable	59, 514, 711 3, 314, 647	0	0	0	4.00 5.00
5.00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7.00	Inventory	2, 189, 251	0	0	0	7.00
3.00	Prepaid expenses	3, 476, 154		0	0	8.00
9.00	Other current assets	694, 703	0	0	0	
10.00	Due from other funds Total current assets (sum of lines 1-10)	0 110, 973, 623	0	0	0	10.00
11.00	FIXED ASSETS	110, 775, 025	0	0	0	111.00
12.00	Land	12, 769, 643	0	0	0	12.00
	Land improvements	3, 369, 169		0	0	13.00
	Accumulated depreciation	-3, 178, 944		0	0	14.00
	Buildings Accumulated depreciation	154, 284, 671 -99, 804, 541	0	0	0	
	Leasehold improvements	1, 004, 506		0	0	
	Accumulated depreciation	-614, 088		0	0	18.00
	Fixed equipment	3, 509, 530		0	0	19.00
	Accumulated depreciation	-1, 468, 034	0	0	0	20.00
	Automobiles and trucks	1, 014, 586		0	0	21.00
	Accumulated depreciation Major movable equipment	-903, 738 72, 753, 746		0	0	
	Accumulated depreciation	-59, 649, 659		0	0	
	Minor equipment depreciable	0,017,007	0	0	0	25.00
	Accumulated depreciation	0	0	0	0	26.00
	HIT designated Assets	0	0	0	0	27.00
	Accumulated depreciation	0	0	0	0	28.00
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	28, 282, 792 111, 369, 639		0	0	29.00 30.00
30.00	OTHER ASSETS	111, 309, 039	0	UU	0	30.00
31.00	Investments	306, 760, 592	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
	Other assets	12, 694, 588		0	0	34.00
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	319, 455, 180 541, 798, 442		0	0	35.00 36.00
50.00	CURRENT LIABILITIES	541,770,442	0	0	0	30.00
37.00	Accounts payable	13, 701, 783	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10, 490, 524		0	0	
39.00	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term) Deferred income	0	0	0	0	
	Accelerated payments	0	0	0	0	41.00
	Due to other funds	0	0	0	0	
	Other current liabilities	13, 436, 716	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	37, 629, 023	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	
47.00 48.00	Notes payable Unsecured Loans	0	0	0	0	
49.00	Other long term liabilities	152, 638, 027	0	0	0	49.00
	Total long term liabilities (sum of lines 46 thru 49)	152, 638, 027	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	190, 267, 050	0	0	0	51.00
	CAPI TAL ACCOUNTS	051 501 000	1			
	General fund balance	351, 531, 392	0			52.00
54.00	Specific purpose fund Donor created - endowment fund balance - restricted			0		53.00 54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
-0 00	replacement, and expansion	251 521 202			0	50 00
59.00 50.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	351, 531, 392 541, 798, 442		0	0	
JU. UU	59)	341, 190, 442	0	0	0	00.0

Heal th	Financial Systems	MARION GENERAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0011	Period: From 07/01/2021 To 06/30/2022	Worksheet G- Date/Time Pro 11/30/2022 9	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		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) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	1.00 0 0 0 0 0 0 0 14 0 0 0 0 0 0	2.00 377,001,360 -25,469,954 351,531,406 351,531,406 351,531,406 14 351,531,392	3.00			5.00 6.00 7.00 8.00 9.00 10.00 11.00 0 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant				
1.00	Fund balances at beginning of period	6.00 0	7.00	8.00	0		1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	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		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Evend belance at and of paried par belance	000	0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0011	Period: From 07/01/2021 To 06/30/2022		pared
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
I. 00	Hospi tal		18, 163, 19	95	18, 163, 195	1.0
2.00	SUBPROVIDER - IPF			0	0	2.0
3.00	SUBPROVIDER - IRF		3, 699, 22	23	3, 699, 223	3.0
1.00	SUBPROVIDER			0	0	4.0
5.00	Swing bed - SNF			0	0	5.0
5.00	Swing bed - NF			0	0	6.0
7.00	SKILLED NURSING FACILITY					7.0
3.00	NURSING FACILITY					8.0
9.00	OTHER LONG TERM CARE					9.0
0.00	Total general inpatient care services (sum of lines 1-9)		21, 862, 41	18	21, 862, 418	10.0
	Intensive Care Type Inpatient Hospital Services					
1.00	I NTENSI VE CARE UNI T		8, 302, 68	36	8, 302, 686	11. (
2.00	CORONARY CARE UNIT					12. (
3.00	BURN INTENSIVE CARE UNIT					13.
4.00	SURGICAL INTENSIVE CARE UNIT					14.
	OTHER SPECIAL CARE (SPECIFY)					15.
	Total intensive care type inpatient hospital services (sum of	lines	8, 302, 68	36	8, 302, 686	
	11-15)		-,,		-,,	
7.00	Total inpatient routine care services (sum of lines 10 and 16)		30, 165, 10	04	30, 165, 104	17.
8.00	Ancillary services		84, 886, 76		84, 886, 769	
9.00	Outpatient services			0 394, 945, 465	394, 945, 465	
20.00	RURAL HEALTH CLINIC			0 0	0	20.0
	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
	HOME HEALTH AGENCY					22.0
23.00	AMBULANCE SERVICES			0 4, 992, 854	4, 992, 854	
	СМНС				.,,	24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
26.00	HOSPICE					26.0
27.00	PROFESSIONAL FEES			0 43, 399, 391	43, 399, 391	27.0
	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	115, 051, 87			
.0.00	G-3, line 1)		110,001,01	10,007,110	000,007,000	20.
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			200, 986, 081		29.0
30.00	ADD (SPECIFY)			0		30.
31.00				0		31.
32.00				0		32.
33.00				0		33.
4.00				0		34.
5.00				0		35.
6.00	Total additions (sum of lines 30-35)			0		36.
7.00	ELIMINATIONS		1, 548, 71			37.
8.00			1, 540, 7	0		38.
9.00				0		39.
0.00				0		40.
10.00				0		40.
12.00	Total deductions (sum of lines 37-41)			1, 548, 711		41.
13.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfor				
+3.00	to Wkst. G-3, line 4)) (transfer		199, 437, 370		43.

Heal th	Financial Systems	MARION GENERAL H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0011	Peri od:	Worksheet G-3	
				From 07/01/2021 To 06/30/2022	Date/Time Pre	nared
				10 00/00/2022	11/30/2022 9:	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part				558, 389, 583	1.00
2.00	Less contractual allowances and discounts or	n patrents' accoun	ts		363, 331, 298	
3.00	Net patient revenues (line 1 minus line 2)				195, 058, 285	3.00
4.00	Less total operating expenses (from Wkst. G-		43)		199, 437, 370	
5.00	Net income from service to patients (line 3 OTHER INCOME	minus line 4)			-4, 379, 085	5.00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				-31, 387, 272	7.00
8.00	Revenues from telephone and other miscellane	ous communication	servi ces		-31, 307, 272	
9.00	Revenue from tel evision and radio service		301 11 003		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 que	ests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical su	upplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than pat	tients			0	17.00
18.00	Revenue from sale of medical records and abs	stracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER OPERATING INCOME				10, 186, 954	24.00
24.50	COVI D-19 PHE Fundi ng				0	24.50
25.00	Total other income (sum of lines 6-24)				-21, 200, 318	
26.00	Total (line 5 plus line 25)				-25, 579, 403	
	BAD DEBT EXPENSE				-109, 449	
	Total other expenses (sum of line 27 and sub				-109, 449	
29.00	Net income (or loss) for the period (line 26	5 minus line 28)			-25, 469, 954	29.00

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0011 Period:	u of Form CMS-2 Worksheet L	
	From 07/01/2021	Parts I-III	
	To 06/30/2022	Date/Time Pre 11/30/2022 9:	pare 15 a
	Title XVIII Hospital	PPS	
		1.00	
PART I - FULLY PROSPECTIVE METHOD		1.00	
CAPITAL FEDERAL AMOUNT			1
00 Capital DRG other than outlier		793, 795	1.
D1 Model 4 BPCI Capital DRG other than outlie	er	0	1
00 Capital DRG outlier payments		16, 892	
D1 Model 4 BPCI Capital DRG outlier payments		0	
	days in the cost reporting period (see instructions)	46.23	
00 Number of interns & residents (see instru	,	0.00	
00 Indirect medical education percentage (see	· · · · · · · · · · · · · · · · · · ·	0.00	
00 Indirect medical education adjustment (mul 1.01) (see instructions)	tiply line 5 by the sum of lines 1 and 1.01, columns 1 and	0	6
00 Percentage of SSI recipient patient days 30) (see instructions)	to Medicare Part A patient days (Worksheet E, part A line	0.00	7.
DO Percentage of Medicaid patient days to to	tal days (see instructions)	0.00	8
00 Sum of lines 7 and 8		0.00	9
.00 Allowable disproportionate share percenta	ge (see instructions)	0.00	10
.00 Disproportionate share adjustment (see in	structions)	0	11
.00 Total prospective capital payments (see in	nstructions)	810, 687	12
		1.00	
PART II - PAYMENT UNDER REASONABLE COST		1.00	
00 Program inpatient routine capital cost (se	ee instructions)	0	1 1
00 Program inpatient ancillary capital cost	,	0	2
00 Total inpatient program capital cost (line		0	3
00 Capital cost payment factor (see instruct)		0	4
00 Total inpatient program capital cost (line		0	5
		1.00	-
PART III - COMPUTATION OF EXCEPTION PAYMEN			
	,	0	
	5	0	
00 Program inpatient capital costs for extra			3
00 Program inpatient capital costs for extra 00 Net program inpatient capital costs (line	,	0	
00 Program inpatient capital costs for extra 00 Net program inpatient capital costs (line 00 Applicable exception percentage (see inst	ructions)	0.00	
00 Program inpatient capital costs for extra 00 Net program inpatient capital costs (line 00 Applicable exception percentage (see inst 00 Capital cost for comparison to payments (1	ructions) ine 3 x line 4)	0. 00 0	5
Program inpatient capital costs for extra Net program inpatient capital costs (line Applicable exception percentage (see inst Capital cost for comparison to payments (l Percentage adjustment for extraordinary c	ructions) ine 3 x line 4) rcumstances (see instructions)	0. 00 0 0. 00	5 6
Program inpatient capital costs for extra Net program inpatient capital costs (line Applicable exception percentage (see inst Capital cost for comparison to payments (l Percentage adjustment for extraordinary c Adjustment to capital minimum payment leve	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6)	0.00 0 0.00 0	5 6 7
 Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instr Capital cost for comparison to payments (l Percentage adjustment for extraordinary ci Adjustment to capital minimum payment leve Capital minimum payment level (line 5 plus 	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7)	0.00 0 0.00 0 0	5 6 7 8
Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see inst Capital cost for comparison to payments () Percentage adjustment for extraordinary co Adjustment to capital minimum payment leve Capital minimum payment level (line 5 plus Current year capital payments (from Part	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7) , line 12, as applicable)	0.00 0 0.00 0 0 0	5 6 7 8 9
Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instr Capital cost for comparison to payments (Percentage adjustment for extraordinary co Adjustment to capital minimum payment leve Capital minimum payment level (line 5 plus Current year capital payments (from Part OC Current year comparison of capital minimum OC Carryover of accumulated capital minimum	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7)	0.00 0 0.00 0 0	5 6 7 8 9 10
 Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instract Capital cost for comparison to payments (I Percentage adjustment for extraordinary ci Adjustment to capital minimum payment level Capital minimum payment level (line 5 plus) Current year capital payments (from Part I Current year comparison of capital minimum payment Level Carryover of accumulated capital minimum Worksheet L, Part III, line 14) 	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7) , line 12, as applicable) n payment level to capital payments (line 8 less line 9) payment level over capital payment (from prior year	0.00 0 0.00 0 0 0 0 0 0	5. 6. 7. 8. 9. 10. 11.
 Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instruct Capital cost for comparison to payments (line Percentage adjustment for extraordinary ci Adjustment to capital minimum payment level Capital minimum payment level (line 5 plust Current year capital payments (from Part 1 Con Carryover of accumulated capital minimum payment Net comparison of capital minimum payment 	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7) , line 12, as applicable) n payment level to capital payments (line 8 less line 9) payment level over capital payment (from prior year level to capital payments (line 10 plus line 11)	0.00 0 0.00 0 0 0 0 0 0 0	5. 6. 7. 8. 9. 10. 11. 12.
 Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instition) Capital cost for comparison to payments (line Adjustment to capital minimum payment level Capital minimum payment level (line 5 plus Current year capital payments (from Part 1 Carryover of accumulated capital minimum payment Net comparison of capital minimum payment Net comparison of capital minimum payment Current year exception payment (if line 12) 	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7) , line 12, as applicable) n payment level to capital payments (line 8 less line 9) payment level over capital payment (from prior year level to capital payments (line 10 plus line 11) 2 is positive, enter the amount on this line)	0.00 0 0.00 0 0 0 0 0 0 0 0 0	5. 6. 7. 8. 9. 10. 11. 12. 13.
 Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instition) Capital cost for comparison to payments (line Percentage adjustment for extraordinary cdition) Adjustment to capital minimum payment level Capital minimum payment level (line 5 plus Current year capital payments (from Part 100) Carryover of accumulated capital minimum payment OU Current year exception percentage (see institution) Net comparison of capital minimum payment Current year comparison of capital minimum payment Carryover of accumulated capital minimum payment Current year exception payment (if line 12) Carryover of accumulated capital minimum payment 	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7) , line 12, as applicable) n payment level to capital payments (line 8 less line 9) payment level over capital payment (from prior year level to capital payments (line 10 plus line 11) 2 is positive, enter the amount on this line) payment level over capital payment for the following period	0.00 0 0.00 0 0 0 0 0 0 0	5. 6. 7. 8. 9. 10. 11. 12. 13.
 Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instition) Capital cost for comparison to payments (line Percentage adjustment for extraordinary ci Adjustment to capital minimum payment level Capital minimum payment level (line 5 plus) Current year capital payments (from Part 1 Current year comparison of capital minimum payment Worksheet L, Part III, line 14) Net comparison of capital minimum payment Current year exception payment (if line 12 in exceptive, enter the amount 	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7) , line 12, as applicable) n payment level to capital payments (line 8 less line 9) payment level over capital payment (from prior year level to capital payments (line 10 plus line 11) 2 is positive, enter the amount on this line) payment level over capital payment for the following period on this line)	0.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0	5 6 7 8 9 10 11 12 13 14
 Program inpatient capital costs for extract Net program inpatient capital costs (line Applicable exception percentage (see instition) Capital cost for comparison to payments (line Percentage adjustment for extraordinary cdition) Adjustment to capital minimum payment level Capital minimum payment level (line 5 plus Current year capital payments (from Part 100) Current year comparison of capital minimum payment Carryover of accumulated capital minimum payment Ou Current year exception payment (if line 12) Current year exception payment (if line 12) Current year of accumulated capital minimum payment 	ructions) ine 3 x line 4) rcumstances (see instructions) el for extraordinary circumstances (line 2 x line 6) s line 7) , line 12, as applicable) n payment level to capital payments (line 8 less line 9) payment level over capital payment (from prior year level to capital payments (line 10 plus line 11) 2 is positive, enter the amount on this line) payment level over capital payment for the following period on this line) tal payment (see instructions)	0.00 0 0.00 0 0 0 0 0 0 0 0 0	5 6 7 8 9 10 11 12 13 14 15