AND SETTLEMENT	SUMMARY	From 01/01/2016 Parts I-III
7.110 02.11222111		To 12/31/2016 Date/Time Prepared:
		5/27/2017 11:06 am
PART I - COST	REPORT STATUS	
Provi der	1. [X] Electronically filed cost report	Date: 5/27/2017 Time: 11:06 am
use only	2. [] Manually submitted cost report	
	3. [0]If this is an amended report enter the number of 4. [F]Medicare Utilization. Enter "F" for full or "L" 1	
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for 19. [N] Final Report for thi (4) Reopened (5) Amended	10. NPR Date: 11. Contractor's Vendor Code: 4 12. [0]If line 5, column 1 is 4: Enter 12. [number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MONROE HOSPITAL (15-0183) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)______Officer or Administrator of Provider(s)

Title

Date

			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	75, 656	34	245, 457	2, 438, 787	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	75, 656	34	245, 457	2, 438, 787	200. 00
Tho ob	ave amounts represent "due to" or "due from"	the applicable	program for th	o alamont of t	he above comple	ov indicated	

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.

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ol

25.00

MCRI F32	_	10.5.	160.	2

4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

25.00 If this provider is an IRF, enter the in-state

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.

Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,

ealth Financial Systems IOSPITAL AND HOSPITAL HEALTH CARE COMPLE		NROE HO	Provider CC		eri od:	worksheet S-2	
				To	rom 01/01/2016 o 12/31/2016		
		Y/N	IME	Direct GME	I ME	5/27/2017 10: Direct GME	40 alli
		1. 00	2. 00	3. 00	4. 00	5. 00	
v1.06 Enter the amount of ACA §5503 awar used for cap relief and/or FTEs the care or general surgery. (see inst	nat are nonprimary		0.00	0.00			61.0
	·	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4. 00	1
st. 10 Of the FTEs in line 61.05, specify specialty, if any, and the number for each new program. (see instruction column 1, the program name, enter program code, enter in column 3, the unweighted count and enter in column FTE unweighted count.	of FTE residents ctions) Enter in in column 2, the che IME FTE umn 4, direct GME				0. 00		61.
p1.20 Of the FTEs in line 61.05, specify program specialty, if any, and the residents for each expanded program instructions) Enter in column 1, the enter in column 2, the program coc 3, the IME FTE unweighted count ar 4, direct GME FTE unweighted count.	e number of FTE am. (see the program name, de, enter in column nd enter in column				0. 00	0.00	61. 2
						1.00	-
ACA Provisions Affecting the Heal							
2.00 Enter the number of FTE residents your hospital received HRSA PCRE 1			lin this cost	reporting peri	od for which	0.00	62.0
2.01 Enter the number of FTE residents during in this cost reporting peri Teaching Hospitals that Claim Resi	that rotated from a od of HRSA THC prog	n Teachi gram. (s	ee instruction		your hospital	0.00	62.0
Has your facility trained resident "Y" for yes or "N" for no in colum	s in nonprovider se	ettings	during this co		period? Enter	N	63.0
				Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te	0.00	2.00	-
Section 5504 of the ACA Base Year				1.00 This base year	is your cost r	3.00 reporting	
in the base year period, the number resident FTEs attributable to rota settings. Enter in column 2 the resident FTEs that trained in your	period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				0.00		
	Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	,
5.00 5.1	1.00		2.00	3.00	4.00	5. 00 0. 000000	
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				0.00	0.00		, 65. 0

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	N: 15-0183		1/01/2016 2/31/2016		epared:
33.00 f this is a Medicare certified ot	ther transplant center e	ntar the cartifi	cation date		1. 00	2. 00	133. 00
in column 1 and termination date,			cation date				133.00
34.00 If this is an organ procurement or and termination date, if applicabl	ganization (OPO), enter		n column 1				134. 00
All Providers 40.00 Are there any related organization	or homo office costs as	dofined in CMS	Dub 15 1		Υ		140. 00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home	office cost	S	ı		140.0
1.00		00			3. 00		
If this facility is part of a chai				name and	l address	of the	
home office and enter the home off 41.00 Name: PRIME HEALTHCARE SERVICES I				tor's Nu	mber: 0100)1	H _{141. 0}
42.00 Street: 3300 GUASTI ROAD, 3RD FLOOP		ioni bi mi	oonti de	201 3 110	mber. oroc	, ·	142. 0
43.00 City: ONTARIO	State: (CA	Zi p Code	э:	9176	1	143.0
						1.00	_
44.00 Are provider based physicians' cos	ts included in Workshoot	Δ2				1. 00 Y	144. 0
++. OUDIE PLOVEUEL DASEU PHYSECEARS COS	ots included til WOLKSNeet	Λ:				T	144.0
					1. 00	2.00	
45.00 If costs for renal services are cl					N	N	145.0
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	lude Medicare utilizatio						
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	gy changed from the previ n column 1. (See CMS Pub.			f	N		146. 0
47 00		!!N!!				1.00	147.0
47.00 Was there a change in the statisti 48.00 Was there a change in the order of						N N	147. 0 148. 0
49.00 Was there a change to the simplifi		,		r no.		N N	149. 0
g		Part A	Part B		itle V	Title XIX	
		1.00	2.00		3. 00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or "		nent for Part A	and Part B.		CFR §413	3. 13)	
55.00 Hospi tal 56.00 Subprovi der - TPF		N N	N N		N N	N N	155. C
57. 00 Subprovi der – TRF		N N	N		N	N N	157. 0
58. 00 SUBPROVI DER		1	14		14	1	158. 0
59. 00 SNF		N	N		N	N	159. 0
60.00 HOME HEALTH AGENCY		N	N		N	N	160. C
61. 00 CMHC			N		N	N	161. 0
61. 10 CORF			N		N	N	161. 1
						1.00	-
Multicampus						1.00	
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has o	ne or more campu	ses in diff	erent CB	SAs?	N	165. 0
	Name O	County 1.00	State Z 2.00	ip Code 3.00	CBSA 4. 00	FTE/Campus 5.00	
66.00 If line 165 is yes, for each							00 166. 0
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)							
						1.00	
	() incentive in the Ameri	can Recovery and		nt Act			
Health Information Technology (HIT						1 1/	167.0
67.00 s this provider a meaningful user	under §1886(n)? Enter					Y	
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10	under §1886(n)? Enter 05 is "Y") and is a meani	ngful user (line), enter	the	l .	0168.0
67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the F	under §1886(n)? Enter 5 is "Y") and is a meani HT assets (see instructi	ngful user (line ons)	167 is "Y"			l .	0168.0
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10	under §1886(n)? Enter 5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do	ngful user (line ons) es this provider	167 is "Y" qualify fo	r a hard		l .	

Health Financial Systems	th Financial Systems MONROE HOSPITAL				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Peri od:	Worksheet S-2	2	
			From 01/01/2016 To 12/31/2016	Part Date/Time Pre	onarad.
		10 12/31/2016	5/27/2017 10:	46 am	
			Begi nni ng	Endi ng	
	1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR becomeriod respectively (mm/dd/yyyy)	01/01/2016	12/31/2016	170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provide	N	(0171.00		
section 1876 Medicare cost plans rep					
"Y" for yes and "N" for no in column	ı 1. If column 1 is yes, e	nter the number of section	on		
1876 Medicare days in column 2. (see	e instructions)				

Heal th	Financial Systems MONROE H	OSPI TAL		In Li∈	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	2
				From 01/01/2016 o 12/31/2016		nared:
				0 12/31/2010	5/27/2017 10:	
				Y/N	Date	
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO re	sponses. Enter	all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	Υ	01/01/2015	1.00
1.00	reporting period? If yes, enter the date of the change in a				0170172010	1.00
			Y/N	Date	V/I	
			1.00	2. 00	3.00	
2.00	Has the provider terminated participation in the Medicare F		N			2. 00
	yes, enter in column 2 the date of termination and in colum	mn 3, "V" for				
2 00	voluntary or "I" for involuntary.		V			2 00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		Y			3. 00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)	o. o a.				
			Y/N	Type	Date	
			1.00	2. 00	3.00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cer	tified Public	Y	Α		4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1					
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
5. 00	column 3. (see instructions) If no, see instructions.	oront from	N N			5. 00
5.00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit rec		l IN			3.00
	those on the fired irriancial statements: If yes, submit rec	concritation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities			1		
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6.00
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7. 00
8.00	Were nursing school and/or allied health programs approved	and/or renewed	l during the	N		8. 00
	cost reporting period? If yes, see instructions.					
9. 00	Are costs claimed for Interns and Residents in an approved	0	cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		ho current	N		10.00
10.00	cost reporting period? If yes, see instructions.	Ji renewed in t	ile cui reiit	į N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	I & R in an Apr	roved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	. a a				55
				1	Y/N	
					1.00	
	Bad Debts					
12. 00	Is the provider seeking reimbursement for bad debts? If yes				N	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection p	policy change o	luring this cos	st reporting	N	13. 00
14 00	period? If yes, submit copy.	anta wai yada If	tuan ann Imat	rueti ene	N	14 00
14.00	If line 12 is yes, were patient deductibles and/or co-paymo Bed Complement	ents warveu? II	yes, see mst	TUCTIONS.	I IV	14. 00
15 00	Did total beds available change from the prior cost reporti	ing period2 If	vas saa instr	ructions	N	15. 00
13.00	Total total bods available change from the prior cost reporti		t A		rt B	13.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	Υ	03/29/2017	Υ	03/29/2017	16. 00
	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					
17 00	instructions)	N		N		17 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 00
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					1
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed	"				
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					1
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	1	1		l	1

	Financial Systems MONROE HC AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0183	Peri od: From 01/01/2016 To 12/31/2016	w of Form CN Worksheet S Part II Date/Time F 5/27/2017 1	S-2 Prepared:		
		Descr	iption	Y/N	Y/N	10. 40 aiii		
			0	1. 00	3.00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
	Nopel Cada Tel Ottlor Bessit Se the Ottlor dajastilones	Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)		1.00			
	Capital Related Cost							
	Have assets been relifed for Medicare purposes? If yes, see					22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	d into during	this cost re	porting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	'If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ing period? I	f yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? If	yes, submit		27. 00		
28. 00	Interest Expense							
29. 00	period? If yes, see instructions. O Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
30. 00	treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see							
31. 00	i nstructi ons.							
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual		32.00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	h provi der-ba	ised physi ci ans?		34.00		
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in	structions.	_	Y/N	Date			
				1.00	2. 00			
	Home Office Costs							
36. 00	Were home office costs claimed on the cost report?			Y		36.00		
37. 00	If line 36 is yes, has a home office cost statement been pr	epared by the	home office?	Y Y		37. 00		
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			- N		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 see instructions.			s, N		39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	THISTI GCTI OHS.		00		00			
	Cost Depart Dropage Contact Information	1.	. 00	2.	00			
41. 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,							
42. 00	respecti vel y.	HMS				42. 00		
	preparer.			IEEE DOOMS	NEEL OF . 2211			
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	714 992-1525		JEFF. BROWN@HMS0	JEFT CE. COM	43. 00		

Health Financial Systems	MONROE H	IOSPI TAL			In Lie	u of Form C	MS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTI ONNAI RE	Provi	der CCN		Peri od:	Worksheet	S-2	
					From 01/01/2016 To 12/31/2016		Prer	ared.
					10 12/31/2010	5/27/2017	10: 4	l6 am
			3.00)				
Cost Report Preparer Contact Informatic	n							
41.00 Enter the first name, last name and the		CE0						41.00
held by the cost report preparer in col	umns 1, 2, and 3,							
respecti vel y.								
42.00 Enter the employer/company name of the	cost report							42.00
preparer.								
43.00 Enter the telephone number and email ac								43.00
report preparer in columns 1 and 2, res	pecti vel y.	1						

						3 12/31/2010	5/27/2017 10:	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1.00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		24	8, 760	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			2.4	0.7/0	0.00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation			24	8, 760	0. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00		8	2, 920	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	32. 00		0	2, 720	0.00		9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		0	0	0.00	-	10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0.00		11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)	34.00		O	O	0.00	U	12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	43.00		32	11, 680	0.00		14. 00
15. 00	CAH visits			02	11,000	0.00	0	15. 00
16. 00	SUBPROVIDER - I PF	40. 00		0	0		Ö	16. 00
17. 00	SUBPROVIDER - I RF	41. 00		0	o o		0	17. 00
18. 00	SUBPROVI DER			_				18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	0		o	19. 00
20. 00	NURSING FACILITY	45. 00		0	0		0	20. 00
21.00	OTHER LONG TERM CARE	46. 00		O	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
24.00	HOSPI CE	116. 00		0	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC	99. 00					0	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			32				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
00.66	outpatient days (see instructions)							00.00
33.00	LTCH non-covered days						l l	33. 00

Provider CCN: 15-0183

				'	0 12/31/2010	5/27/2017 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	10 4
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	oomponent.	I TO XVIII	THE WIN	Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9, 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 312	601	4, 075			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)	0	564				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				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	2, 312	601	4, 075			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	139	8	983			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		0	0			13. 00
14. 00	Total (see instructions)	2, 451	609	5, 058	0.00	202.00	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	
17. 00	SUBPROVI DER - I RF	0	0	0	0.00	0.00	
18. 00							18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0			
20. 00			0	0	0.00		
21. 00	OTHER LONG TERM CARE			0			21. 00
22. 00	HOME HEALTH AGENCY	0	0	0			
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	l e	
24. 00	HOSPI CE	0	0	0	0.00	0.00	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	0	0	0			
25. 10	CMHC - CORF	0	0	0			
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00	l e	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	l e	ı
27. 00	,				0.00	202. 00	ı
28. 00	3		0	139			28. 00
29. 00	· ·	0					29. 00
30. 00	, ,			0			30. 00
31. 00				0			31. 00
32. 00		0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00

Provider CCN: 15-0183

Full Time Equivalents Component Full Time Equivalents Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title XVIII Title XIX Patients Title XVIII Title XIX Total All Total XII Total XIII Tot						12/31/2010	5/27/2017 10:	
Nonpaid Nonp			Full Time	_	Di sch	arges		
No.			Equi val ents					
11.00 12.00 13.00 14.00 15.00		Component	Nonpai d	Title V	Title XVIII	Title XIX		
1.00								
8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col 2 for the portion of LIDP room available beds) 2. 00 HM0 and other (see instructions) 3. 00 HM0 IPF Subprovider 4. 00 3. 00 6. 00 Hospi tal Adults & Peds. Swing Bed SNF 6. 00 Hospi tal Adults & Peds. Swing Bed NF 7. 00 Hospi tal Adults & Peds. Swing Bed NF 8. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 10. 00 SURGI CALI INTENSIVE CARE UNIT 11. 00 SURGI CALI INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 OTHER SPECIAL CARE (SPECIFY) 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IRF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 CON NURSING FACILITY 19. 00 SUBPROVIDER AGE 19. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 20. 00 OTHER LONG TERM CARE 20. 00 HOME HEALTH AGENCY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 CAHC - CMHC 23. 00 MMC - CMHC 24. 10 HOSPICE (CON-distinct part) 24. 10 HOSPICE CONFICE 24. 10 CMHC - CMHC 25. 10 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 CMAL HEALTH CLINIC 27. 00 CMC - CMHC 28. 10 CMHC - CMHC 29. 00 CMC - CMHC 29. 00 CMC - CMHC 20. 00 CMC - CMH			11. 00			14. 00	15. 00	
3. 00 HM0 IPF Subprovi der 4. 00 HM0 IRF Subprovi der 5. 00 Hospi tal Adul ts & Peds. Swing Bed SNF 6. 00 Hospi tal Adul ts & Peds. Swing Bed NF 7. 00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGI CAL INTENSI VE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 O O O O O O O O O O O O O O O O O O	1. 00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2		0	658	11	1, 486	1.00
4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 13.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 SKILLED NURSING FACILITY 19.00 OTHER SPECIAL CARE 19.00 SKILLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 19.00 SKILLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 19.00 SKILLED NURSING FACILITY 19.00 SCHALLED NURSING FACILITY 19.00 SCHALLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 19.00 SCHALLED NURSING CARE 19.00 OTHER LONG TERM CARE 19.00 SCHALLED NURSING CARE 20.00 OND HORS ICE 20.00 OND CHALLED CORE 20.00 OND CHALLED COR	2.00	HMO and other (see instructions)			0	0		2. 00
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.00 7.00	3.00	HMO IPF Subprovider				0		
6.00		HMO IRF Subprovider				0		
Total Adults and Peds. (exclude observation beds) (see instructions)	5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
Beds (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 9.00 0.00 9.00	6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
9.00 CORONARY CARE UNIT 9.00 10.00 11.	7. 00	· · · · · · · · · · · · · · · · · · ·						7. 00
10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 15. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER R 18. 00 SUBPROVIDER R 19. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 21. 00 OTHER LONG TERM 26. 00 RURAL HEALTH CLINIC 21. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 21. 00 CMHC - CORF 22. 00 RURAL HEALTH CLINIC 21. 00 CMHC - CORF 22. 00 RURAL HEALTH CLINIC	8.00	INTENSIVE CARE UNIT						8. 00
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 12. 00 12. 00 12. 00 12. 00 13. 00 10. 00	9.00	CORONARY CARE UNIT						9. 00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 19.00 NURSING FACILITY 19.00 OTHER LONG TERM CARE 19.00 OTHER LONG TERM CARE 19.00 OTHER LONG TERM CARE 19.00 AMBULATORY SURGICAL CENTER (D. P.) 19.00 CAH visits 10.00 OTHER LONG TERM CARE 19.00 OTHER LONG TERM C	10.00	BURN INTENSIVE CARE UNIT						10.00
13. 00	11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 19. 00 OTHER LONG TERM CARE 20. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 20. 00 CAH visits 20. 00 O O O O O O O O O O O O O O O O O	12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 19. 00 ONURSING FACILITY 19. 00 OTHER LONG TERM CARE 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 OTHER LONG TERM CARE 23. 00 OTHER LONG TERM CARE 24. 00 OTHER LONG TERM CARE 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC	13.00	NURSERY						13. 00
16. 00 SUBPROVI DER - I PF 0. 00 0 0 0 0 16. 00 17. 00 SUBPROVI DER - I RF 0. 00 0 0 0 17. 00 18. 00 SUBPROVI DER 18. 00 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 0. 00 20. 00 NURSI NG FACI LI TY 0. 00 21. 00 OTHER LONG TERM CARE 0. 00 22. 00 HOME HEALTH AGENCY 0. 00 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 0. 00 24. 00 HOSPI CE 0. 00 25. 00 CMHC - CMHC 24. 10 25. 00 CMHC - CORF 0. 00 26. 00 RURAL HEALTH CLINI C 0. 00 26. 00 26. 00 27. 00 0 0 28. 10 0 0 29. 10 0 20. 10 0 20. 10 0 20. 10 0 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 10 28. 10 29. 10 29. 10 20. 10 20. 10 20. 10 20. 10 21. 00 22. 00 23. 00 24. 10 25. 10 26. 00 26. 00 27. 10 28. 10 29. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 21. 00 22. 00 23. 00 24. 10 25. 10 26. 00 26. 00 27. 10 28. 10 29. 10 20. 10 20. 10 20. 10 20. 10 20. 10 21. 00 22. 00 23. 00 24. 10 25. 10 26. 00 27. 10 28. 10 29. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 21. 00 22. 00 23. 00 24. 10 25. 10 26. 00 27. 10 28. 10 29. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 21. 00 22. 00 23. 00 24. 10 25. 10 26. 00 27. 10 28. 10 29. 10 20. 10 20. 10 20. 10 20. 10 20. 10 21. 00 22. 00 23. 00 24. 10 25. 10 26. 00 27. 10 28. 10 29. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 20. 10 21. 00 22. 00 23. 00 24. 10 25. 10 26. 00 27. 10 28. 10 29. 10 20	14.00	Total (see instructions)	0.00	0	658	11	1, 486	14.00
17. 00 SUBPROVIDER - IRF 0. 00 0 0 0 17. 00 18. 00 SUBPROVIDER 18. 00 19. 00 SKILLED NURSING FACILITY 0. 00 20. 00 NURSING FACILITY 0. 00 21. 00 OTHER LONG TERM CARE 0. 00 22. 00 HOME HEALTH AGENCY 0. 00 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 0. 00 24. 00 HOSPICE 0. 00 24. 10 HOSPICE 0. 00 25. 00 CMHC - CMHC 0. 00 25. 10 CMHC - CORF 0. 00 26. 00 RURAL HEALTH CLINIC 0. 00 26. 00 26. 00 27. 00 0 0 28. 10 0 0 29. 10 0 0 20. 17. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 00 28. 10 29. 10 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 00 28. 10 29. 10 29. 10 20. 17. 00 20. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19	15.00	CAH visits						15. 00
18. 00 SUBPROVI DER 18. 00 19. 00 19. 00 19. 00 19. 00 20. 00 19. 00 20. 00	16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16. 00
19. 00 SKILLED NURSING FACILITY 0. 00 20.	17. 00	SUBPROVI DER - I RF	0.00	0	0	0	0	17. 00
20. 00 NURSING FACILITY 0. 00 21. 00 21. 00 21. 00 21. 00 22. 00 HOME HEALTH AGENCY 0. 00 22. 00 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 0. 00 23. 00 40.	18.00	SUBPROVI DER						18. 00
21.00 OTHER LONG TERM CARE 0.00 0 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0.00 23.00 24.00 HOSPICE 0.00 24.00 24.00 24.00 25.00 CMHC - CMHC 0.00 25.10 CMHC - CORF 0.00 25.10 CMHC - CORF 0.00 26.00 26.00 26.00	19. 00	SKILLED NURSING FACILITY	0.00					19. 00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE 0.00 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 10 26. 00 26. 00 27. 10 28. 10 29. 00 29. 10 20. 00	20.00	NURSING FACILITY	0.00					20. 00
23.00 AMBULATORY SURGICAL CENTER (D.P.) 0.00 24.00 HOSPICE 0.00 24.10 HOSPICE (non-distinct part) 24.10 25.00 CMHC - CMHC 0.00 25.10 CMHC - CORF 0.00 26.00 RURAL HEALTH CLINIC 0.00 26.00	21. 00	OTHER LONG TERM CARE	0.00				0	21. 00
24. 00 HOSPICE 0. 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 0. 00 25. 10 CMHC - CORF 0. 00 26. 00 RURAL HEALTH CLINIC 0. 00	22. 00	HOME HEALTH AGENCY						22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 24. 10 25. 00 25. 10 26. 00	23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
25. 00 CMHC - CMHC	24.00	HOSPI CE	0.00					24. 00
25. 10 CMHC - CORF 0. 00 25. 10 26. 00 RURAL HEALTH CLINIC 0. 00 26. 00	24. 10	HOSPICE (non-distinct part)						24. 10
26.00 RURAL HEALTH CLINIC 0.00 26.00	25.00	CMHC - CMHC	0.00					25. 00
	25. 10	CMHC - CORF	0.00					25. 10
	26.00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25 FEDERALLY QUALI FI ED HEALTH CENTER 0. 00 26. 25	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00 Total (sum of lines 14-26) 0.00 27.00	27.00	Total (sum of lines 14-26)	0.00					27. 00
28.00 Observation Bed Days 28.00	28.00	Observation Bed Days						28. 00
29. 00 Ambul ance Tri ps 29. 00	29. 00	Ambul ance Tri ps						29. 00
30.00 Employee discount days (see instruction) 30.00	30.00	Employee discount days (see instruction)						30. 00
31.00 Employee discount days - IRF	31.00	Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions) 32.00	32.00							32.00
32.01 Total ancillary labor & delivery room 32.01	32. 01							32. 01
outpatient days (see instructions) 33.00 LTCH non-covered days 33.00		outpatient days (see instructions)						

Provider CCN: 15-0183

Instructions Non-physical an anesthetist Part 0						10	3 12/31/2016	Date/lime Pre 5/27/2017 10:	
PART II - MACE DATA					on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷	
MARIES MARIES 1.00 lotal salar les (see 200.00 10,629,578 419,631.00 25.33 10.00 10.00 10.00 2			1. 00	2.00				6. 00	
Total salaries (see 200 00 10,629,578 0 10,629,578 419,631 00 25.33 1.00									4
Instructions	1. 00		200. 00	10, 629, 578	0	10, 629, 578	419, 631, 00	25. 33	1.00
Non-physic of an anestherist Part 0	2. 00	instructions)							2.00
4. 00 Physician-Part A - Amain's strative and a strative services a stratic stratic and a strative services a stratic services and a strative services and a strative services a stratic services and a strative services and a strative services a stratic services and a strative services a stratic services a stratic services and a strative services a stratic services a stratic services and a strative services a stratic services and a strative services a stratic services a stratic services a stratic services and a strative services a stratic services a stratic services and a strative services and a strative services a strative services and a strat	3. 00	1		0	0	0	0. 00	0. 00	3.00
Admin I strative 4. OP Physicians - Part A - Teaching 5.00 Physicians - Part A - Teaching 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00	В		0	0	0	0. 00	0. 00	4.00
Physic ian Part B for	4. 01			0	0	0	0.00		
Non-physician-Part B for hospitul-based RRIC and FBHC services Non-physician Part S for hospitul-based RIC and FBHC services Non-physician Part S for hospitul-based RIC and FBHC services Non-physician Part S for hospitul-based RIC and FBHC services Non-physician Part S for hospitul-based RIC and FBHC services Non-physician Part A	5.00	Physician and Non		0	0	0	0.00	0. 00	5. 00
7.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0	6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6.00
Contracted interns and residents (in an approved programs) South Programs South Progr	7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
1000 1000	7. 01	Contracted interns and residents (in an approved		0	О	О	0.00	0.00	7. 01
9.00 SNF	8. 00	Home office and/or related		0	0	0	0.00	0. 00	8. 00
Instructions OTHER WAGES & RELATED COSTS		SNF	44. 00	0 29 843		-			
11.00 Contract labor: Direct Patient Co Care Car	10.00	instructions)		27,010		27,010	1, 170. 00	25. 55	10.00
12.00 Contract labor: Top level 0 0 0 0 0 0 0 0 0	11. 00	Contract Labor: Direct Patient		0	0	0	0.00	0. 00	11. 00
Services	12. 00	Contract Labor: Top Level management and other		0	О	0	0.00	0. 00	12. 00
A - Administrative Administra	13. 00	servi ces		0	0	0	0. 00	0. 00	13.00
Wage-related costs	14. 00	Home office and/or related		484, 442	0	484, 442	9, 581. 00	50. 56	14. 00
14.02 Related organization salaries 0 0 0 0 0 0 0 0 0	14 01	wage-related costs		0	0	0	0.00	0.00	14 01
Administrative Home office and Contract Home office Administrative Home office Administrative Home office Administrative Home office Related Costs (core) (see 12,691,028 17,005 18.00 Mage-related Costs (other) Home office wage-related Home	14. 02	Related organization salaries		0	0	0	0. 00	0. 00	14. 02
Physicians Part A - Teaching		- Administrative		_	_				
17. 00 Wage-related costs (core) (see instructions) 18. 00 Wage-related costs (other) 0 0 0 0 0 0 0 0 0	10.00	Physicians Part A - Teaching				0		0.00	10.00
18.00 Wage-related costs (other) (see instructions) 18.00 18.00 19.00	17. 00	Wage-related costs (core) (see		2, 691, 028	0	2, 691, 028			17. 00
19.00 Excluded areas	18. 00	Wage-related costs (other)		0	0	0			18. 00
21. 00 Non-physician anesthetist Part B 22. 00 Physician Part A - Administrative 22. 01 Physician Part A - Teaching 23. 00 Physician Part B 24. 00 Wage-related costs (RHC/FOHC) 25. 00 Interns & residents (in an approved program) 25. 50 Related orgainzation 25. 50 Wage-related 25. 51 Related orgainzation 25. 52 Wage-related 26. 00 Verriead office & Contract Physicians Part A - Teaching - Wage-related 26. 00 Verriead office & Contract Physicians Part A - Teaching - Wage-related 26. 00 Employee Benefits Department 4. 00 249, 200 0 249, 200 6, 594. 00 37. 79 26. 00 Employee Benefits Department 27. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Excluded areas		7, 555 0	0	7, 555 0			19. 00 20. 00
Administrative Physician Part A - Teaching O O O Physician Part B O O O Administrative Physician Part B O O O Physician Part B O O O Administrative Physician Part B O O O Administrative Physician Part B O O O Administrative D O O O Administrative Administrative D O O O Administrative D O O O Administrative D O O O Administrative Administrative D O O O Administrative D O O O Administrative Administrative D O O O O O Administrative Administr	21. 00	A		0	0	0			21. 00
22. 01	22. 00	B Physician Part A -		0	0	0			22. 00
23. 00 Physician Part B	22 01	1		0		0			22 01
25. 00				-	1	_			23. 00
approved program Approved pr	24. 00	Wage-related costs (RHC/FQHC)		0	ō	0			24. 00
25. 51 Related orgainzation		approved program)		_	_				
25. 52 Home office: Physician Part A		Related orgainzation				o o			25. 51
wage-related Home office & Contract O O O O D 25.53 Physicians Part A - Teaching - wage-related OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 249,200 O 249,200 6,594.00 37.79 26.00	25. 52	Home office: Physician Part A		0	0	О			25. 52
Physicians Part A - Teaching -	25 53	wage-rel ated		0	0	<u> </u>			25 53
26.00 Employee Benefits Department 4.00 249,200 0 249,200 6,594.00 37.79 26.00	20.00	Physicians Part A - Teaching - wage-related							
	26 00			249 200		249 200	6 504 00	27 70	26 00
				·			·		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2017 | Prepared: | To 12/3

							5/27/2017 10:	46 am
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	•	0	173, 686			30.00
31. 00	Laundry & Linen Service	8. 00		0	0	0.00		31.00
32.00	Housekeepi ng	9. 00	283, 754	0	283, 754	25, 339. 00	11. 20	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	1	10. 00	285, 200	0	285, 200	22, 376. 00	12. 75	34.00
35.00	Di etary under contract (see		0	0	0	0. 00	0. 00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	0	0	0.00		36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37.00
38. 00	Nursing Administration	13. 00	992, 224	0	992, 224	14, 293. 00	69. 42	38.00
39. 00	Central Services and Supply	14. 00	162, 540	0	162, 540	10, 988. 00	14. 79	39.00
40.00	Pharmacy	15. 00	395, 119	0	395, 119	12, 126. 00	32. 58	40.00
41.00	Medical Records & Medical	16. 00	190, 557	0	190, 557	10, 291. 00	18. 52	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Heal th Financial Systems MONROE HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0183 Period: Worksheet S-3

						From 01/01/2016 To 12/31/2016		
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		10, 629, 578	0	10, 629, 578	419, 631. 00	25. 33	1.00
	instructions)							
2.00	Excluded area salaries (see		29, 843	0	29, 843	1, 178. 00	25. 33	2.00
	instructions)							
3.00	Subtotal salaries (line 1		10, 599, 735	0	10, 599, 73!	418, 453. 00	25. 33	3.00
	minus line 2)							
4.00	Subtotal other wages & related		484, 442	0	484, 442	9, 581. 00	50. 56	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		2, 691, 028	0	2, 691, 028	0.00	25. 39	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		13, 775, 205	0	13, 775, 20!	428, 034. 00	32. 18	6.00
7.00	Total overhead cost (see		4, 273, 010	0	4, 273, 010	171, 518. 00	24. 91	7.00
		1		i .		I	1	

instructions)

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0183	Period: Worksheet S-3 From 01/01/2016 Part IV
		To 12/31/2016 Date/Time Prepared:

	To 12/31/2016	Date/Time Prep 5/27/2017 10:4	
		Amount	, c
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		l
1.00	401K Employer Contributions	116, 953	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	1, 675, 282	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	ol	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9, 641	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	ol	14.00
15. 00	'Workers' Compensation Insurance	90, 643	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		l
	TAXES		l
	FICA-Employers Portion Only	0	17. 00
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	798, 508	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))	_	
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	2, 691, 027	24. 00
05.00	Part B - Other than Core Related Cost		05.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: Worksheet S-3 From 01/01/2016 Part V To 12/31/2016 Date/Time Prepared:

		To	12/31/2016	Date/Time Prep 5/27/2017 10:4	
	Cost Center Description		Contract Labor	Benefit Cost	70 diii
	· · · · · · · · · · · · · · · · · · ·		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	2, 691, 027	1. 00
2.00	Hospi tal		0	2, 683, 472	2. 00
3.00	Subprovi der - IPF		0	0	3. 00
4. 00	Subprovi der - I RF		0	0	4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF		0	0	8. 00
9. 00	Hospi tal -Based NF		0	0	9. 00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12. 00	Separately Certified ASC		0	0	12.00
13. 00	Hospi tal -Based Hospi ce		0	0	13. 00
	Hospital-Based Health Clinic RHC		0	0	14. 00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC		0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	7, 555	18. 00

SPI TAL	nancial Systems MONRO UNCOMPENSATED AND INDIGENT CARE DATA	DE HOSPITAL Provider CO	CN: 15-0183	Period: From 01/01/2016	u of Form CMS-2 Worksheet S-1	
				To 12/31/2016	Date/Time Pre 5/27/2017 10:	pare 46 a
					1. 00	
Unc	compensated and indigent care cost computation					
00 Cos	st to charge ratio (Worksheet C, Part I line 202 colu	mn 3 divided by li	ne 202 colum	n 8)	0. 194807	1.
Med	licaid (see instructions for each line)					
00 Net	t revenue from Medicaid				1, 682, 773	2.
	d you receive DSH or supplemental payments from Medic					3
	line 3 is "yes", does line 2 include all DSH or supp		from Medicai	d?		4
- 1	line 4 is "no", then enter DSH or supplemental payme	nts from Medicaid			0	5
- 1	dicaid charges				19, 317, 389	
- 1	dicaid cost (line 1 times line 6)	/1: 7 :	6.1.	0 15 16	3, 763, 163	
	fference between net revenue and costs for Medicaid p zero then enter zero)	rogram (line / min	us sum of II	nes 2 and 5; IT	2, 080, 390	8
	Idren's Health Insurance Program (CHIP) (see instruc	tions for each lin	e)			
- 1	t revenue from stand-alone CHIP				0	
- 1	and-alone CHIP charges				0	
4	and-alone CHIP cost (line 1 times line 10)				0	11
	fference between net revenue and costs for stand-alon	e CHIP (line 11 mi	nus line 9;	if < zero then	0	12
	ter zero) mer state or Local government indigent care program (ass instructions f	on cook line	`		-
	t revenue from state or local indigent care program (0	13
	arges for patients covered under state or local indig				0	
10)	3 1	ent care program (Not Theradea	THE THES O OF	O	'-
/	, ate or local indigent care program cost (line 1 times	line 14)			0	15
	fference between net revenue and costs for state or I		program (li	ne 15 minus line	0	
13;	if < zero then enter zero)					
	compensated care (see instructions for each line)					
	vate grants, donations, or endowment income restrict	9	,		0	
	vernment grants, appropriations or transfers for supp				0	
	tal unreimbursed cost for Medicaid , CHIP and state a	nd local indigent	care program	s (sum of lines	2, 080, 390	19
[8,	12 and 16)		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
	arity care charges for the entire facility (see instr			0 0	0	
	st of patients approved for charity care (line 1 time	s line 20)		0 0	0	_
	rtial payment by patients approved for charity care			0 0	0	
00 Cos	st of charity care (line 21 minus line 22)			0 0	0	23
					1. 00	
	es the amount in line 20 column 2 include charges for		nd a Length	of stay limit		24
	posed on patients covered by Medicaid or other indige		oamom! - ! -	النسال بنجاء كم طاء	2	25
	line 24 is "yes," charges for patient days beyond a			in or stay iimit	0	
	tal bad debt expense for the entire hospital complex				0	
	dicare bad debts for the entire hospital complex (see n-Medicare and non-reimbursable Medicare bad debt exp		s lino 27\		0	
				- 20)		
00 Cos	st of non-Medicare and non-reimbursable Medicare bad st of uncompensated care (line 23 column 3 plus line	, ,	I TIMES IIN	e 28)	0	

Heal th	ı Financial Systems	MONROE HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der CO	1	Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Pre 5/27/2017 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 371, 472	1, 371, 47			1
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(0 62, 740		
3.00	00300 OTHER CAP REL COSTS	240, 200	0 7/4 054	2 014 15	0	0	
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	249, 200	2, 764, 954	3, 014, 15, 9, 609, 90			
7.00	00700 OPERATION OF PLANT	1, 540, 730 173, 686	8, 069, 177 806, 408				
8.00	00800 LAUNDRY & LINEN SERVICE	173,000	000, 400 N	700, 07	82, 629		
9. 00	00900 HOUSEKEEPI NG	283, 754	177, 483	461, 23			1
10.00	01000 DI ETARY	285, 200	194, 385			479, 585	1
11.00	01100 CAFETERI A	0	0		0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	992, 224	111, 273	1, 103, 49	7 0	1, 103, 497	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	162, 540	123, 516	286, 05		283, 362	
15. 00	01500 PHARMACY	395, 119	94, 404				
16.00	01600 MEDI CAL RECORDS & LI BRARY	190, 557	69, 864	260, 42			
17. 00	01700 SOCI AL SERVI CE	0	0		0	0	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 190, 401	283, 284	1, 473, 68	-62, 586	1, 411, 099	30.00
31.00	03100 I NTENSI VE CARE UNI T	655, 293	77, 144				1
32. 00	03200 CORONARY CARE UNIT	033, 273	,,, 144	752, 45	0 22, 333	0	
33.00	03300 BURN INTENSIVE CARE UNIT		0		0	ő	
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT	o	0		0	0	
40.00	04000 SUBPROVI DER - I PF	0	0		0	0	
41.00	04100 SUBPROVI DER - I RF	0	0		0 0	0	41.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
45. 00	04500 NURSING FACILITY	0	0	(0	0	
46. 00	04600 OTHER LONG TERM CARE	0	0		0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 110 171	980, 883	2, 099, 05	4 -95, 358	2, 003, 696	- 00
51.00	05100 RECOVERY ROOM	1, 118, 171	900, 003 N	2, 099, 03	-90, 300 n	2,003,696	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	
53. 00	05300 ANESTHESI OLOGY		521, 200	521, 200	0	521, 200	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	702, 651	708, 393			1, 375, 247	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	1
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	20, 307	13, 398			20, 783	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	52, 925	0	52, 92	5 0	52, 925	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1 004 70	0 0	0	
60.00	06000 LABORATORY	817, 148	184, 632	1, 001, 78	-2, 694		1
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U	0		0	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	
63.00			0		0	0	02.00
64. 00	06400 I NTRAVENOUS THERAPY		0		0	Ö	
65.00	06500 RESPI RATORY THERAPY	328, 129	46, 638	374, 76	7 -21, 398	353, 369	
66.00	06600 PHYSI CAL THERAPY	105, 203	1, 046			106, 249	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00	1	129, 621	37, 859	167, 480	-4, 310		1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	
71.00		0	3, 835, 222	3, 835, 22			1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	00.000	(00.04)	1, 674, 445		
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	608, 868	608, 86	0	608, 868	1
74. 00 75. 00	07500 ASC (NON-DISTINCT PART)		0			0 0	1
, 5. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	· · · · · · · · · · · · · · · · · · ·	σ ₁		1 , 3. 00
88. 00	08800 RURAL HEALTH CLINIC	Ol	0		0	0	88. 00
89. 00			0		o o	0	1
90.00	09000 CLI NI C	0	0		0 0	0	1
91.00		1, 206, 876	1, 135, 826	2, 342, 70	-84, 935	2, 257, 767	91.00
92. 00							92. 00
	OTHER REIMBURSABLE COST CENTERS			T			
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	1	0	0	
95.00	1	0	0		0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
97.00	1 1	0	0	'	0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC		0			0	
	09910 CORF		0			0	
	10000 I &R SERVICES-NOT APPRVD PRGM		0			-	100.00
	10100 HOME HEALTH AGENCY		0	1			101.00
101 00	JITOTOUTHOWE HEALTH AGENCY	(1)	()		.) (1)	[]	

Health Financial Systems	MONROE HOS				u of Form CMS-	<u> 2552-10</u>
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2016 To 12/31/2016	Doto/Time Dro	nonod.
				To 12/31/2016	Date/Time Pre 5/27/2017 10:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati		40 am
cost center bescription	Sai ai i cs	Other	+ col . 2)	ons (See A-6)		
			1 001. 2)	ons (see n o)	(col. 3 +-	
					col . 4)	
	1, 00	2. 00	3. 00	4. 00	5. 00	
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	(0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	o	0	(o	0	106. 00
107. 00 10700 LIVER ACQUISITION	o	0	(o	0	107. 00
108.00 10800 LUNG ACQUISITION	o	0	(o	0	108. 00
109.00 10900 PANCREAS ACQUISITION	o	0	(o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	O	(0	0	110. 00
111.00 11100 ISLET ACQUISITION	o	O	(0	0	111. 00
113.00 11300 INTEREST EXPENSE		O	(0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	o	O	(0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	(0	0	115. 00
116. 00 11600 HOSPI CE	o	0	(0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10, 599, 735	22, 217, 329	32, 817, 064	1 0	32, 817, 064	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
191. 00 19100 RESEARCH	0	0	(0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	(0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	194. 00
194.01 07951 PUBLIC RELATIONS/MARKETING	29, 843	159, 411	189, 254	1 0	189, 254	194. 01
200.00 TOTAL (SUM OF LINES 118-199)	10, 629, 578	22, 376, 740	33, 006, 318	0	33, 006, 318	200.00

Peri od: Worksheet A From 01/01/2016 Date/Time Prepared: 5/27/2017 10:46 am

				5/27/2017 10:	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	CENEDAL CEDVICE COST CENTEDS	6. 00	7.00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	7, 456	1, 698, 934		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	490		l e e e e e e e e e e e e e e e e e e e	2. 00
3.00	00300 OTHER CAP REL COSTS	0		l .	3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 011, 460		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 542, 623	5, 830, 986		5. 00
7.00	00700 OPERATION OF PLANT	-7, 434	1, 197, 389		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	82, 629		8. 00
9. 00	00900 HOUSEKEEPI NG	0	378, 608		9. 00
10.00	01000 DI ETARY	-122, 497	357, 088		10.00
11.00	01100 CAFETERI A	0	0		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1, 103, 497		13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	283, 362		14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-562	486, 830 239, 316		16. 00
	01700 SOCIAL SERVICE	0	237, 310		17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS			'	17.00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 411, 099		30.00
31.00	03100 I NTENSI VE CARE UNI T	0	1		31. 00
32.00	03200 CORONARY CARE UNIT	0	0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0		34.00
40. 00	04000 SUBPROVI DER - I PF	0	0		40. 00
41. 00	04100 SUBPROVI DER – I RF	0	0		41. 00
43. 00	04300 NURSERY	0	0		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	1	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	0		/	46.00
50. 00	05000 OPERATING ROOM	-451, 695	1, 552, 001		50.00
51. 00	05100 RECOVERY ROOM	0	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö		52. 00
53.00	05300 ANESTHESI OLOGY	-521, 200	O		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 375, 247	,	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56. 00
57.00	05700 CT SCAN	0	20, 783		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	52, 925		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60. 00	06000 LABORATORY	-19, 500	979, 586		60. 00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	353, 369		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	l .	i e e e e e e e e e e e e e e e e e e e	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0			67. 00
	06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-3, 000	160, 170		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 160, 777	'	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 674, 445		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	608, 868		73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	•	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0)	75. 00
00.00	OUTPATIENT SERVICE COST CENTERS				00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC				89. 00 90. 00
91. 00	09100 EMERGENCY	-890, 569	1, 367, 198		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-070, 307	1, 307, 170		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				1 /2.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00	09500 AMBULANCE SERVICES	0	Ö		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
	09900 CMHC	0	0)	99. 00
	09910 CORF	0	0)	99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM	0			100.00
101.00	10100 HOME HEALTH AGENCY	0	0	<u> </u>	101. 00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0	0		105. 00
100.00	10000 NIDNET ACCUISETION	1 0	1 0	<u>'</u> 1	1100.00

Health Financial Systems MONRO RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES MONROE HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0183

Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared:

			5/27/2017 10:46 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7.00	
106. 00 10600 HEART ACQUI SI TI ON	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-5, 551, 134	27, 265, 930	118.00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	194. 00
194.01 07951 PUBLIC RELATIONS/MARKETING	0	189, 254	194. 01
200.00 TOTAL (SUM OF LINES 118-199)	-5, 551, 134	27, 455, 184	200. 00

Heal th Financial Systems

RECLASSIFICATIONS

Provider CCN: 15-0183
Provider CCN: 15-018

					10 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am	
		Increases			0, 27, 2017 TO TO AIII	
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - RENT AND LEASE-BUILDING					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	314, 367	1.00	0
2.00		0.00	0	0	2. 00	0
3.00		0. 00	0	0	3.00	0
	TOTALS		0	314, 367		
	B - RENT AND LEASE-EQUIPMENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	287, 131	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 639	2. 00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5. 00	
6.00		0.00	0	0	6. 00	
7.00		0.00	0	0	7. 00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9. 00	
10.00		0.00	0	0	10.00	
11. 00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00		0	14.00	0
	TOTALS		0	292, 770		
	C - UTILITIES					
1.00	OPERATION OF PLANT	7. 00	0	224, 729	1.00	
2.00		0.00	0	0	2. 00	0
	TOTALS		0	224, 729		
	D - LAUNDRY EXPENSE					
1.00	LAUNDRY & LINEN SERVICE			<u>82, 6</u> 29	1.00	0
	TOTALS		0	82, 629		
	E - IMPLANTS AND PROTHESIS					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	1, 674, 445	1.00	O
	PATI ENTS	+	+			
	TOTALS		0	1, 674, 445		_
500.00	Grand Total: Increases		0	2, 588, 940	500.00	Ü

Health Financial Systems RECLASSIFICATIONS MONROE HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0183

					'	0 12/31/2010	5/27/2017 10: 46 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - RENT AND LEASE-BUILDING						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	224, 391	10		1. 00
2.00	MEDICAL RECORDS & LIBRARY	16. 00	0	16, 459	0		2. 00
3.00	EMERGENCY	<u>91.</u> 00	0	7 <u>3, 5</u> 17	0		3. 00
	TOTALS		0	314, 367	'		
	B - RENT AND LEASE-EQUIPMENT						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 694			1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	12, 959			2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	2, 694			3.00
4.00	PHARMACY	15. 00	0	2, 693			4. 00
5.00	MEDICAL RECORDS & LIBRARY	16. 00	0	2, 694			5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	62, 586			6. 00
7.00	INTENSIVE CARE UNIT	31. 00	0	22, 553			7. 00
8.00	OPERATING ROOM	50.00	0	95, 358			8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	35, 797			9. 00
10.00	CT SCAN	57. 00	0	12, 922			10.00
11. 00	LABORATORY	60.00	0	2, 694			11.00
12.00	RESPI RATORY THERAPY	65.00	0	21, 398			12. 00
13.00	ELECTROCARDI OLOGY	69. 00	0	4, 310			13.00
14.00	EMERGENCY	<u>91.</u> 00	0	1 <u>1, 4</u> 18			14. 00
	TOTALS		0	292, 770			
	C - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	223, 339			1.00
2.00	MEDICAL RECORDS & LIBRARY	<u>16.</u> 00	0	<u>1, 3</u> 90			2. 00
	TOTALS		0	224, 729)		
	D - LAUNDRY EXPENSE						
1.00	HOUSEKEEPI NG		•	8 <u>2, 6</u> 29			1.00
	TOTALS		0	82, 629			
	E - IMPLANTS AND PROTHESIS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 674, 445	0		1. 00
	PATI ENTS	↓	+		 		
	TOTALS		0	1, 674, 445			
500. 00	Grand Total: Decreases		0	2, 588, 940)		500. 00

				Т	o 12/31/2016	Date/Time Pre 5/27/2017 10:	pared: 46 am
				Acqui si ti ons		072772017 10.	TO dill
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	0	1, 300, 000	0	1, 300, 000	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	1, 073, 260	7, 043, 126	0	7, 043, 126		4. 00
5.00	Fixed Equipment	4, 210, 931	2, 437, 835	0	2, 437, 835	l	5. 00
6.00	Movable Equipment	539, 428	328, 656	0	328, 656	0	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	5, 823, 619	11, 109, 617	0	11, 109, 617	l .	8. 00
9.00	Reconciling Items	0	116, 386	0	116, 386	1	9. 00
10. 00	Total (line 8 minus line 9)	5, 823, 619	10, 993, 231	0	10, 993, 231	0	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
		4 00	Assets				
	DART I ANALYSIS OF CHANGES IN CARLTAL ASSE	6.00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				1. 00
2.00	Land	1, 300, 000	0				2.00
2. 00 3. 00	Land Improvements	0	0				
4. 00	Buildings and Fixtures	8, 116, 386	0				3. 00 4. 00
5.00	Building Improvements	6, 648, 766	0				5.00
6. 00	Fixed Equipment Movable Equipment	868, 084	0				6. 00
7. 00	HIT designated Assets	000, 004	0				7.00
8.00	Subtotal (sum of lines 1-7)	16, 933, 236	0				8.00
9. 00	Reconciling Items	116, 336	0				9.00
10.00	Total (line 8 minus line 9)	16, 816, 850	0				10.00
10.00	Total (Tine o minus Tine 7)	10,010,030	Ψ				1 10.00

Heal th	Financial Systems	MONROE HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0183	Peri od:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		pared:
					12, 01, 2010	5/27/2017 10:	46 am
			Sl	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	40.00	11 00	instructions)		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	9.00	10.00	11.00	12. 00	13. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 371, 472	N Z, LINES I a	110 Z			1.00
2.00	CAP REL COSTS-BLDG & FIXI	1, 3/1, 4/2	0		0	J 0	2.00
3.00	Total (sum of lines 1-2)	1, 371, 472	0		0	0	
3.00	Total (suil of Titles 1-2)	SUMMARY O	E CADITAI		U U	U	3.00
		30WWART OF	CALLIAL				
	Cost Center Description	Other	Total (1) (sum				
	'	Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 371, 472			ļ	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			ļ	2. 00
3.00	Total (sum of lines 1-2)	0	1, 371, 472				3. 00

Heal th	n Financial Systems	MONROE HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2016 To 12/31/2016		
		COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1.00	2.00	2) 3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	9, 142, 471	0	9, 142, 47	1 0. 578959	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 648, 766		6, 648, 76		0	2.00
3.00	Total (sum of lines 1-2)	15, 791, 237	0	15, 791, 23	7 1. 000000	0	3.00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6.00	7.00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS	0		0 1, 375, 751	320, 006	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 373, 731	62, 740	2. 00
3. 00	Total (sum of lines 1-2)	0	0		0 1, 376, 241	382, 746	3. 00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART III DECONCILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	NIERS 3, 177	0		ol o	1, 698, 934	1. 00
2.00	CAP REL COSTS-BLDG & FTXT	3,1//	l	•	0 0	63, 230	2. 00
3.00	Total (sum of lines 1-2)	3, 177		•	0 0		
3.00	Total (Sam of Tilles 1 2)	3, 177	٥	ı	ο ₁	1, 702, 104	3. 00

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0183

				To To	12/31/2016	Date/Time Prep	
				Expense Classification on		5/27/2017 10: 4	40 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 0	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other	A	-911	ADMINISTRATIVE & GENERAL	5. 00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)		-				
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7.00	Telephone services (pay stations excluded) (chapter	A	-7, 434	OPERATION OF PLANT	7. 00	О	7. 00
	21)						
8. 00	Television and radio service (chapter 21)	В	-10, 272	ADMINISTRATIVE & GENERAL	5. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-1, 912, 606			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-921, 337			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-122, 497	DI ETARY	10. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	О	17. 00
18. 00	Sale of medical records and	В	-562	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
20.00	books, etc.)		0		0.00	0	20.00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	(chapter 21)			0.5 551 00070 5150 0 5157			0.4.00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
20.00	therapy costs in excess of		Ü		37.30		22. 30
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)	1 400					
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	U	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest	[
33. 00 33. 01	OTHER INCOME RECRUITING	B A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 00 33. 01
	•		, , , , , ,			٠	

Health Financial Systems MONROE HC	JSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES	Provider CCN: 15-0183	Peri od:	Worksheet A-8	
		From 01/01/2016 To 12/31/2016	Date/Time Prep 5/27/2017 10:4	
	Expense Classification o	n Worksheet A		
	To/From Which the Amount is	s to be Adjusted		
Cost Center Description Basis/Code (2) Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00 2.00	3.00	4. 00	5. 00	
33. 02 LATE FEES A -8, 651	ADMINISTRATIVE & GENERAL	5.00	0	33. 02
33. 03 LOSS ON INVESTMENTS A -2, 516, 857	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04 CONTRI BUTI ONS A -2, 575	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05 GRANT FUNDS A -409	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
50.00 TOTAL (sum of lines 1 thru 49) -5,551,134				50.00
(Transfer to Worksheet A,				
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.

46 am
1. 00
2. 00
3. 00
4. 00
4. 01
4. 02
5. 00
0 0 0 0 2 2

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	0.00 PRIME HLTHCARE 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9. 00		0.00	9. 00
10.00		0.00	10. 00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- $(1) \ \ \text{Use the following symbols to indicate interrelationship to related organizations:}$
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems		MONROE HOS	PLIAL		In Lie	u of Form CMS	5-2552-10
STATEME OFFICE		SERVICES FROM	RELATED ORGANIZATIO	ONS AND HOME	Provi der	CCN: 15-0183	Peri od: From 01/01/2016	Worksheet A	
							To 12/31/2016	Date/Time P 5/27/2017 1	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A	RESULT OF TE	RANSACTI ONS	WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:							
1.00	4, 279	9	9						1. 00
2.00	3, 177	11	1						2. 00
3.00	490	9	9						3. 00
4.00	846, 716	0	ol						4. 00
4.01	16, 283	0	ol						4. 01
4.02	-1, 792, 282	0	ol						4. 02

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

5.00

nas not	been posted to norksheet 7,	cordinate transfer 2, the amount arrowable should be trial eated in cordinat for this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
-			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	HOME OFFICE	6.00
7. 00 8. 00		7.00
8.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

5.00

-921, 337

PROVIDER BASED PHYSICIAN ADJUSTMENT

69. 00 ELECTROCARDI OLOGY

91. 00 EMERGENCY

0.00

0.00

0.00

Provider CCN: 15-0183

From 01/01/2016 12/31/2016 Date/Time Prepared:

3,000

C

C

890, 569

1, 912, 606

0

0

0

6.00

7.00

8.00

9.00

10.00

200.00

5/27/2017 10:46 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 5. 00 ADMI NI STRATI VE & GENERAL 1. 00 1.00 26, 642 26, 642 2.00 13. 00 NURSING ADMINISTRATION 60,000 60,000 171, 400 30, 825 2.00 3.00 50. 00 OPERATING ROOM 451, 695 3.00 451, 695 4.00 53. 00 ANESTHESI OLOGY 521, 200 521, 200 0 4.00 C 60. 00 LABORATORY 0 5.00 19,500 19,500 0 0 5.00 6.00 69. 00 ELECTROCARDI OLOGY 3,000 3,000 0 0 0 6.00 0 7.00 91. 00 EMERGENCY 890, 569 890, 569 0 0 7.00 0 8.00 8.00 0 00 0 0 0 9.00 0.00 9.00 0.00 10.00 10.00 1, 972, 606 1, 912, 606 30, 825 60,000 200. 00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1. 00 2.00 8.00 9.00 12. 00 13.00 14.00 5. 00 ADMINISTRATIVE & GENERAL 1.00 0 0 1.00 2.00 13. 00 NURSING ADMINISTRATION 2, 540, 099 127, 005 0 0 0 2.00 3.00 50. 00 OPERATING ROOM 0 0 3.00 0 53. 00 ANESTHESI OLOGY 0 0 0 4.00 0 4.00 0 5.00 60. 00 LABORATORY 0 0 0 0 5 00 69. 00 ELECTROCARDI OLOGY 6.00 0 6.00 7.00 91. 00 EMERGENCY 0 0 0 0 7.00 0 0 8.00 0.00 0 8.00 0.00 0 9.00 0 9.00 0 10.00 0.00 10.00 2, 540, 099 127, 005 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCF Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 5. OO ADMINISTRATIVE & GENERAL 1. 00 1.00 0 0 26, 642 2.00 13. 00 NURSING ADMINISTRATION 0 2, 540, 099 0 2.00 3.00 50. 00 OPERATING ROOM 0 451, 695 3.00 4.00 53. 00 ANESTHESI OLOGY 0 0 4.00 0 521, 200 60. 00 LABORATORY 5.00 0 0 0 19,500 5 00

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2, 540, 099

6.00

7.00

8.00

9.00

10.00

200.00

| Period: | Worksheet B | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0183

					o 12/31/2016		pared:
			CAPITAL RELATED COSTS			5/27/2017 10:	46 alli
	Cost Center Description	Not Eypopsos	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	Net Expenses for Cost	DLUG & FIXI	WVBLE EQUIP	BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1. 00	2.00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	1, 698, 934	1, 698, 934	I			1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	63, 230		63, 230			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 011, 460		1			4. 00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	5, 830, 986 1, 197, 389	299, 380 45, 224	1		6, 591, 798 1, 295, 057	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	82, 629	9, 379			92, 357	8. 00
9.00	00900 HOUSEKEEPI NG	378, 608				467, 977	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	357, 088	78, 134 0	1		521, 483 0	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 103, 497	Ö	Ö	١	1, 393, 484	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	283, 362	27, 630	1		359, 524	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	486, 830 239, 316		1		615, 271 298, 944	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0	i		0	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 411, 099	126, 968	4, 725	347, 907	1, 890, 699	30. 00
31. 00	03100 INTENSIVE CARE UNIT	709, 884	80, 665			985, 067	31.00
32. 00	03200 CORONARY CARE UNIT	0	0			0	32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	-	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	Ö	-	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	Ö	Ö	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1, 552, 001	188, 133	7, 002	326, 797	2, 073, 933	50. 00
51. 00	05100 RECOVERY ROOM	0	0	1		0	51. 00
52. 00 53. 00	O5200 DELIVERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	0	0 2, 210	0 82	-	0 2, 292	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 375, 247	120, 828			2, 292 1, 705, 929	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0		0	55. 00
56. 00 57. 00	05600	20, 783	0 7, 894	0 294		0 34, 906	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	52, 925		1			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	_	-	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	979, 586 0	41, 007 0	1, 526	238, 820 0	1, 260, 939 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00	O6300 BLOOD STORING, PROCESSING & TRANS. O6400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65.00	06500 RESPI RATORY THERAPY	353, 369		l .		459, 888	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	106, 249	2, 041	76 0		139, 113 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	Ö		0	68. 00
69.00	06900 ELECTROCARDI OLOGY	160, 170	0	0		198, 053	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 160, 777	46, 084	0 1, 715		0 2, 208, 576	70. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 674, 445	0	0		1, 674, 445	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	608, 868	0	0		608, 868	
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	0		0	74. 00 75. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	88. 00 89. 00
90.00	09000 CLINIC	0	0	Ö	0	0	90.00
91. 00	09100 EMERGENCY	1, 367, 198	183, 427	6, 827	352, 722	1, 910, 174	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
96. 00 97. 00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD		0	0		0	96. 00 97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	o	o	0	98. 00
99.00	09900	0	0	0		0	99. 00 99. 10
77. 10	107710 00Kl	ı o	<u> </u>	1 0	<u>ı</u> 9	0	77. 10

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part I Provider CCN: 15-0183

				o 12/31/2016	Date/Time Prepared: 5/27/2017 10:46 am
		CAPITAL RELATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal
	for Cost			BENEFI TS	
	Allocation (from Wkst A			DEPARTMENT	
	col. 7)				
	0	1. 00	2, 00	4. 00	4A
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0	0 110.00
111. 00 11100 SLET ACQUISITION	O O	O	0	0	0 111.00
113. 00 11300 NTEREST EXPENSE					113. 00 114. 00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0			0 115.00
116. 00 11600 HOSPI CE		0	0	0	0 115.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	27, 265, 930	1, 321, 079	49, 165	3, 025, 045	26, 865, 288 118. 00
NONREI MBURSABLE COST CENTERS	21, 203, 730	1, 321, 077	47, 103	3, 023, 043	20, 003, 200 110. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0 190, 00
191. 00 19100 RESEARCH	0	0	0	o	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	377, 450	14, 050	o	391, 500 192. 00
193.00 19300 NONPALD WORKERS	O	0	0	o	0 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	o	0	0	o	0 194. 00
194.01 07951 PUBLIC RELATIONS/MARKETING	189, 254	405	15	8, 722	198, 396 194. 01
200.00 Cross Foot Adjustments					0 200. 00
201.00 Negative Cost Centers		0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	27, 455, 184	1, 698, 934	63, 230	3, 033, 767	27, 455, 184 202. 00

Provider CCN: 15-0183

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am

						5/27/2017 10:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT 7. 00	LINEN SERVICE	0.00	10. 00	
	GENERAL SERVICE COST CENTERS	5. 00	7.00	8. 00	9. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 591, 798					5. 00
7. 00	00700 OPERATION OF PLANT	409, 175	1, 704, 232				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	29, 180	11, 992				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	147, 858 164, 763	7, 937 99, 908	1	623, 772 37, 000	823, 154	9. 00 10. 00
11. 00	01100 CAFETERI A	104, 703	99, 900 0		37,000	269, 805	
13. 00	01300 NURSI NG ADMI NI STRATI ON	440, 273	0		0	207, 003	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	113, 592	35, 330		13, 084	0	14. 00
15. 00	01500 PHARMACY	194, 395	15, 983			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	94, 452	4, 853	0	1, 797	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		597, 368	162, 350	1		355, 464	1
31. 00	1	311, 233	103, 143	1	38, 198	27, 068	
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0		0	0	33.00
40. 00	04000 SUBPROVI DER - I PF		0		0	0	40.00
41. 00	04100 SUBPROVI DER – I RF		0		0	0	41.00
43. 00	1 1	o	0	o o	O	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	o	0	0	44. 00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	,		,			
50. 00	05000 OPERATING ROOM	655, 261	240, 559	1		0	50.00
51.00	05100 RECOVERY ROOM	0	0	1	-	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	_	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	724 538, 990	2, 826 154, 499		1, 046	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-DI AGNOSTI C	538, 990	154, 499		57, 218	0	55.00
56. 00	1		0		0	0	56.00
57. 00	05700 CT SCAN	11, 029	10, 094		3, 738	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	24, 174	10, 008	1	3, 706	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	Ö		0	59. 00
60.00	06000 LABORATORY	398, 395	52, 434	. 0	19, 419	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	+ I	0	0	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	1	0	10.000	0	0	0	
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	145, 302 43, 953	13, 092	1	4, 849	0	65. 00
66. 00 67. 00	+ I	43, 953	2, 610		967	0	66. 00 67. 00
68. 00	1 1		0		0	0	
69. 00	1 1	62, 575	0		0	0	
70. 00	1 1	0	0	o o	o	Ö	70.00
71. 00		697, 792	58, 927	0	21, 823	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	529, 043	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	192, 372	0	0	0	0	73. 00
74. 00		0	0	0	0	0	74. 00
75. 00		0	0	0	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS	1					
88. 00	I I	0	0	0	0	0	88. 00
89. 00 90. 00	I I	0	0		0	0	89. 00 90. 00
91.00	1	603, 521	234, 541	,	86, 861	1, 933	
92. 00	1	003, 321	234, 341		00, 001	1, 733	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
94. 00		O	0	0	0	0	94. 00
95.00	1	0	0	0	0	0	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	o	0	97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
99. 00	1	0	0	0	0	0	
	09910 CORF	0	0	0	0	0	
	0 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.0	0 10100 HOME HEALTH AGENCY	0	0	y O	0	0	101. 00
105 0	SPECIAL PURPOSE COST CENTERS 0 10500 KIDNEY ACQUISITION	0	0	0	O	0	105. 00
	0 10600 HEART ACQUISITION	0	0	1			105.00
.00.0		<u>'</u>			<u> </u>	0	1.00.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MONROE HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0183

					5/27/2017 10:46 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10.00
107. 00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	o	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	o	0 111.00
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	o	0 115.00
116. 00 11600 HOSPI CE	0	0	0	o	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 405, 420	1, 221, 086	133, 529	444, 840	654, 270 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	o	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	123, 695	482, 628	0	178, 740	168, 884 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	O	0 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	0 194. 00
194. 01 07951 PUBLIC RELATIONS/MARKETING	62, 683	518	0	192	0 194. 01
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	o	0 201. 00
202.00 TOTAL (sum lines 118-201)	6, 591, 798	1, 704, 232	133, 529	623, 772	823, 154 202. 00

Provider CCN: 15-0183

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am

			10	12/31/2016	5/27/2017 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMINISTRATION	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	269, 805					11.00
13.00 01300 NURSING ADMINISTRATION	13, 034	1, 846, 791				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	521, 530			14. 00
15. 00 01500 PHARMACY	0	0	0	831, 568		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	9, 391	0	0	0	409, 437	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
30.00 O3000 ADULTS & PEDIATRICS	47, 451	673, 472	0	ol	17, 567	30.00
31. 00 03100 NTENSI VE CARE UNI T	25, 233	332, 609	0	Ö	6, 161	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	o	0, 131	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	О	0	o	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	O	0	o	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44. 00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
ANCILLARY SERVICE COST CENTERS	0	<u> </u>	U _I	<u>U</u>	0	40.00
50. 00 05000 OPERATI NG ROOM	39, 652	191, 980	0	ol	67, 713	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	O	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	О	0	o	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	O	4, 509	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	24, 285	0	0	0	19, 044	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	436	0	0	0	28, 021	57.00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	1, 973	0	0	U O	6, 336 0	58. 00 59. 00
60. 00 06000 LABORATORY	27, 187	69, 404	0	0	46, 332	60.00
60. 01 06001 BLOOD LABORATORY	0	0,, 101	Ö	ő	0, 332	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o	0	o	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	9, 619	0	0	0	11, 749	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2, 561	0	0	0	2, 016	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	U O	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 396	17, 635	0	0	4, 946	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0,570	17,033	0	Ö	4, 740	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 017	O	406, 879	Ö	61, 028	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	114, 651	o	68, 400	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 061	0	0	831, 568	18, 402	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS		ما		ما	0	00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	U	0	U	0	88. 00
90. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00 90. 00
91. 00 09100 EMERGENCY	44, 509	561, 691	0	0	47, 213	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	44, 507	301, 071	o o	ĭ	47, 213	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	97.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC 99. 10 09910 CORF	0		0	0	0	99. 00 99. 10
100.00 10000 &R SERVICES-NOT APPRVD PRGM			0	٥		100.00
101. 00 10100 HOME HEALTH AGENCY		o n	n	ol O		101.00
SPECIAL PURPOSE COST CENTERS		<u> </u>		<u> </u>		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
		'	<u> </u>	'		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MONROE HOSPITAL Provider CCN: 15-0183

| Peri od: | Worksheet B | From 01/01/2016 | Part | | To 12/31/2016 | Date/Time Prepared: | Part | P

			10	12/31/2010	5/27/2017 10: 4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15. 00	16. 00	
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 1	06.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 1	07.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 1	08.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 1	09.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 1	10.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 1	11.00
113.00 11300 INTEREST EXPENSE					1	13.00
114.00 11400 UTILIZATION REVIEW-SNF					1	14.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 1	15.00
116. 00 11600 HOSPI CE	0	0	0	0	0 1	16.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	269, 805	1, 846, 791	521, 530	831, 568	409, 437 1	18.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 1	90.00
191. 00 19100 RESEARCH	0	0	0	0	0 1	91.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 1	92.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 1	93.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 1	94.00
194. 01 07951 PUBLIC RELATIONS/MARKETING	0	0	0	0	0 1	94. 01
200.00 Cross Foot Adjustments					2	200.00
201.00 Negative Cost Centers	0	0	0	0	0 2	201. 00
202.00 TOTAL (sum lines 118-201)	269, 805	1, 846, 791	521, 530	831, 568	409, 437 2	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0183 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/27/2017 10:46 am Cost Center Description SOCIAL SERVICE Total Subtotal Intern & Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3. 912. 074 3 912 074 30.00 0 0 31.00 03100 INTENSIVE CARE UNIT 1, 854, 663 1, 854, 663 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 0000 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34 00 Ω 34 00 0 40.00 04000 SUBPROVIDER - IPF 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44 00 44.00 Ω 0 0 45.00 04500 NURSING FACILITY 0 45.00 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 3, 358, 188 0 3, 358, 188 0 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 11.397 0 11.397 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2, 499, 965 2, 499, 965 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 0 56.00 05700 CT SCAN 88, 224 88. 224 57.00 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 122, 708 122, 708 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 1, 874, 110 1, 874, 110 60.00 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0000000000000 63.00 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 644, 499 644, 499 65.00 06600 PHYSI CAL THERAPY 191, 220 191, 220 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67 00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 286, 605 286, 605 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 3, 465, 042 0 3, 465, 042 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 386, 539 0 2, 386, 539 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 662, 271 0 1, 662, 271 73.00 0 74 00 07400 RENAL DIALYSIS 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 0 0 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 Ω 0 0 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 3, 490, 443 0 3, 490, 443 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 0 0 95.00 0 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96, 00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 99.00 09900 CMHC 0 0 0 0 99.00 99. 10 09910 CORF 0 99.10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 101.00

Health Financial Systems	MONROE HOS	_			u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B
				From 01/01/2016 To 12/31/2016	Part I Date/Time Prepared:
				10 12/31/2016	5/27/2017 10:46 am
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	37 2 77 2 0 17 10. 10 dill
			Residents Cos		
			& Post		
			Stepdown		
			Adjustments		
	17. 00	24. 00	25. 00	26.00	
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KIDNEY ACQUISITION	0	0		0 0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	106. 00
107.00 10700 LIVER ACQUISITION	0	0		0 0	107. 00
108.00 10800 LUNG ACQUISITION	0	0		0 0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	110. 00
111.00 11100 I SLET ACQUISITION	0	0		0 0	111. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	115. 00
116. 00 11600 HOSPI CE	0	0		0 0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	25, 847, 948		0 25, 847, 948	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190. 00
191. 00 19100 RESEARCH	0	0		0 0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 345, 447		0 1, 345, 447	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0 0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	194. 00
194. 01 07951 PUBLIC RELATIONS/MARKETING	0	261, 789		0 261, 789	194. 01
200.00 Cross Foot Adjustments		0		0 0	200. 00
201.00 Negative Cost Centers	0	0		0 0	201. 00
202.00 TOTAL (sum lines 118-201)	0	27, 455, 184		0 27, 455, 184	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2016 | Part II |
| To 12/31/2016 | Date/Time Prepared: | 5/27/2017 | 10: 46 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0183

					12/31/2016	5/27/2017 10:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost denter bescription	Assigned New	DEDU & IIXI	WVDLL LQ011	Subtotal	BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	21, 507		22, 307	22, 307	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	299, 380		310, 522	3, 310	5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	45, 224 9, 379		46, 907 9, 728	373 0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	6, 208		6, 439	610	9. 00
10.00	01000 DI ETARY	0	78, 134		81, 042	613	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	2, 132	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	27, 630 12, 499		28, 658 12, 964	349 849	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	3, 795		3, 936	410	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	126, 968		131, 693	2, 558	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	80, 665	3, 002	83, 667	1, 408 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	o	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	О	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	U O	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		.0.00
50.00	05000 OPERATING ROOM	0	188, 133	7, 002	195, 135	2, 403	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0 2, 210	0 82	0 2, 292	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	120, 828		125, 325	1, 510	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	О	0	56. 00
57. 00	05700 CT SCAN	0	7, 894		8, 188	44	57. 00
58. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	7, 827	291	8, 118	114	58. 00 59. 00
59. 00 60. 00	06000 LABORATORY	0	41, 007	1	42, 533	1, 756	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				О		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	10, 239	1 1	10, 620	705	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 041	76	2, 117	226	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	. 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	279	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46, 084	1, 715	47, 799	0	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	40,004	1, 713	47, 777	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	Ö	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0		٥	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00	09000 CLINIC	0	0	0	ō	0	90. 00
91.00	09100 EMERGENCY	0	183, 427	6, 827	190, 254	2, 594	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
04.00	OTHER REIMBURSABLE COST CENTERS		0		ما	0	04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		0	0	94. 00 95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0		ol	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0	0	ō	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	o	0	98. 00
	09900 CMHC	0	0	0	0	0	99. 00
99. 10	09910 CORF 10000 L&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	99. 10 100. 00
	PITOGOO I WIT GEG-NOT ALLINOD FROM	١	0	ı	Ч	U	1.00.00

				o 12/31/2016	Date/Time Prepa 5/27/2017 10:46	red: am
		CAPI TAL REI	ATED COSTS			
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0 10	01. 00
SPECIAL PURPOSE COST CENTERS			_			
105. 00 10500 KI DNEY ACQUISITION	0	0	0	0		05.00
106. 00 10600 HEART ACQUISITION	0	0	0	0		06. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		07. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		08.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		9. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		10.00
111. 00 11100 SLET ACQUISITION	0	0	0	이		11.00
113. 00 11300 I NTEREST EXPENSE						13.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		_	_	_		14.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		15. 00
116. 00 11600 HOSPI CE	0	0	0	0		16. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 321, 079	49, 165	1, 370, 244	22, 243 11	18.00
NONREI MBURSABLE COST CENTERS				ام	0 40	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		90.00
191. 00 19100 RESEARCH	0	0	44.050	0		91.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	377, 450	14, 050	391, 500		92.00
193. 00 19300 NONPAI D WORKERS	0	0	0	0	•	93. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	100		94. 00
194. 01 07951 PUBLI C RELATI ONS/MARKETI NG	U	405	15	420	64 19	
200.00 Cross Foot Adjustments		0				00.00
201.00 Negative Cost Centers		1 400 004	42 220	1 7/2 1/4		01. 00
202.00 TOTAL (sum lines 118-201)	ı O	1, 698, 934	63, 230	1, 762, 164	22, 307 20	JZ. UU

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To 12/31/2016 | Date/Time Prepared: | Part | To 12/31/2016 | Part | To 12/31/2016 | Part | To 12/31/2017 | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0183

				T		Date/Time Pre 5/27/2017 10:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	OCNEDAL CEDIU OF COST OFNITEDS	5. 00	7. 00	8.00	9. 00	10.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 00 7. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	313, 832 19, 480	66, 760				2. 00 4. 00 5. 00 7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	1, 389 7, 039	470 311	11, 587 0	14, 399	04.247	8. 00 9. 00
10. 00 11. 00	01100 CAFETERI A	7, 844	3, 914 0	0	854 0	94, 267 30, 898	
13.00	01300 NURSI NG ADMI NI STRATI ON	20, 961	0	0	0	0	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	5, 408 9, 255	1, 384 626		302 137	0	14. 00 15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 497	190		41	0	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17. 00
30.00	03000 ADULTS & PEDIATRICS	28, 440	6, 360			40, 707	30. 00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	14, 817	4, 040 0	2, 252 0	882	3, 100 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	0	ő	o	0	33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER – TPF	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	Ö	0	ő	Ö	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	31, 196	9, 423	Ιο	2, 057	0	50.00
51. 00	05100 RECOVERY ROOM	31, 170	9, 423			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	-	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	34 25, 661	111 6, 052	0	24 1, 321	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	25, 001	0, 032	ő	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	525 1, 151	395 392		86 86	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 131	0	0	0	0	59.00
60.00	06000 LABORATORY	18, 967	2, 054	0	448	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	О	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	0	o	0	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	6, 918	0 513	0	0 112	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 093	102	•	22	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	0	0	0	0	67. 00
68. 00 69. 00		2, 979	0	0	0	0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	ő	o	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	33, 226	2, 308	0	504	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	25, 187 9, 159	0	0	0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	0	Ō	O	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	O	0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	28, 733	0 9, 188	0	0 2, 005	0 221	90. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	20, 733	7, 100		2,003	221	92.00
0.4.00	OTHER REIMBURSABLE COST CENTERS						
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0	0	0	0	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	o	0	Ö	o	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98. 00 99. 00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC		0	0	0	0	98. 00 99. 00
99. 10	09910 CORF	0	0	Ö	o	0	99. 10
	10000 L&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00 101. 00
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	<u> </u>	0	1 0	<u> </u>	0	101.00
	10500 KIDNEY ACQUISITION	0	0	0	l		105. 00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MONROE HOSPITAL Provider CCN: 15-0183

					5/27/2017 10:	46 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	O	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	304, 959	47, 833	11, 587	10, 269	74, 926	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5, 889	18, 907	0	4, 126	19, 341	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 PUBLIC RELATIONS/MARKETING	2, 984	20	0	4	0	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	313, 832	66, 760	11, 587	14, 399	94, 267	202. 00

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To 12/31/2016 | Date/Time Prepared: | Part | To 12/31/2016 | Part | To 12/31/2016 | Part | To 12/31/2017 | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0183

			To	12/31/2016	Date/Time Pre 5/27/2017 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	30, 898	1				11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	1, 493		36, 101			13. 00 14. 00
15. 00 01500 PHARMACY		- 1	30, 101	23, 831		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 075	- 1	0	25, 651	10, 149	16. 00
17. 00 01700 SOCIAL SERVICE	C	1	0	o	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 434	1 ' 1	0	0	433	30. 00
31. 00 03100 INTENSIVE CARE UNIT	2, 890	1	0	0	152	31.00
32. 00 03200 CORONARY CARE UNIT	C	- 1	0	0	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	C		0	0	0	33. 00 34. 00
40. 00 04000 SUBPROVI DER - 1 PF			0	0	0	40.00
41. 00 04100 SUBPROVI DER - RF			0	0	0	41. 00
43. 00 04300 NURSERY		o o	0	o	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	C	o	0	o	0	44.00
45.00 04500 NURSING FACILITY	C	o	0	o	0	45. 00
46.00 O4600 OTHER LONG TERM CARE	C	0	0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS	4 544	0.55/	0	ما	1 ((0	
50. 00 05000 0PERATI NG ROOM	4, 541	2, 556	0	0	1, 668	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	C		0	0	0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY			0	0	111	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 781		0	0	469	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	_,	ol ol	0	o	0	55. 00
56. 00 05600 RADI OI SOTOPE	C	o	0	О	0	56. 00
57.00 05700 CT SCAN	50	0	0	0	690	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	226	1	0	0	156	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.440	1 -1	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	3, 113	924	0	0	1, 141 0	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY) 	U	٩	U	60. 01 61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		ol ol	0	o	0	63. 00
64.00 06400 INTRAVENOUS THERAPY	C	o	0	О	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 102	. 0	0	0	289	65. 00
66. 00 06600 PHYSI CAL THERAPY	293	0	0	0	50	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0	0	0	0	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	389	0	0	0	0 122	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	389	235	0	0	0	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 147		28, 164	0	1, 503	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	,,,,,,	ol ol	7, 937	o	1, 749	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 267	o	0	23, 831	453	73. 00
74. 00 07400 RENAL DI ALYSI S	C	0	0	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	C	0	0	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS		ا	-	ام		
88. 00 08800 RURAL HEALTH CLINIC	C		0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC			0	0	0	89. 00 90. 00
91. 00 09100 EMERGENCY	5, 097	7, 478	0	0	1, 163	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,077	7,470	J	ď	1, 103	92.00
OTHER REIMBURSABLE COST CENTERS	'	'		'		
94.00 09400 HOME PROGRAM DIALYSIS	C	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	C	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0	0	0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC			0	0	0	98. 00 99. 00
99. 10 09910 CORF			0	٥	0	99. 00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM			0	o O		100.00
101. 00 10100 HOME HEALTH AGENCY		ol ol	Ö	ol		101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	C	o	0	0	0	105. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MONROE HOSPITAL Provider CCN: 15-0183

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To 12/31/2016 | Date/Time Prepared: | Part | To 12/31/2016 | Part | To 12/31/2016 | Part | To 12/31/2017 | Part | Part

				12/01/2010	5/27/2017 10: 46	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 10	06. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0	0 10	07. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 10	08. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 10	09. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 1	10.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 1	11. 00
113.00 11300 INTEREST EXPENSE					11	13.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					11	14.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 1	15. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 1	16. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	30, 898	24, 586	36, 101	23, 831	10, 149 1	18. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 19	90.00
191. 00 19100 RESEARCH	0	0	0	0	0 19	91. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 19	92.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 19	93. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 19	94.00
194. 01 07951 PUBLIC RELATIONS/MARKETING	0	0	0	0	0 19	94. 01
200.00 Cross Foot Adjustments					20	00.00
201.00 Negative Cost Centers	0	o	0	0	0 20	01. 00
202.00 TOTAL (sum lines 118-201)	30, 898	24, 586	36, 101	23, 831	10, 149 20	02. 00

Heal th	n Financial Systems	MONROE HO	SPI TAL		In Lie	u of Form CMS	-2552-10
	ATION OF CAPITAL RELATED COSTS		Provi der Co	F	eriod: from 01/01/2016 fo 12/31/2016	Worksheet B Part II	epared:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	372772017 10	. 40 diii
		17. 00	24.00	25. 00	26.00		
1 00	GENERAL SERVICE COST CENTERS	1		I	I		1 00
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 14. 00 15. 00 16. 00 17. 00	01300 NURSI NG ADMINISTRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LI BRARY	0					13. 00 14. 00 15. 00 16. 00 17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>					17.00
30. 00 31. 00 32. 00 33. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0 0 0 0	235, 313 117, 636 0 0	1	235, 313 117, 636 0		30. 00 31. 00 32. 00 33. 00
34. 00 40. 00 41. 00 43. 00 44. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	0 0 0	0 0 0		0 0		34. 00 40. 00 41. 00 43. 00 44. 00
45. 00		0	Ö	Č	o o		45. 00
46. 00		0	0	(0		46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	248, 979		248, 979		50.00
51. 00 52. 00 53. 00 54. 00 55. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0 0 0 0	0 0 2, 572 163, 119	(51. 00 52. 00 53. 00 54. 00 55. 00
56. 00 57. 00		0	9, 978		9, 978		56. 00 57. 00
58.00		0	10, 243	C	10, 243		58.00
59. 00 60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	70, 936 0		70, 936 0		59. 00 60. 00 60. 01
64. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0 0	0 00 000	(0 00 000		61. 00 62. 00 63. 00 64. 00
65. 00 66. 00	1 1	0	20, 259 4, 903		20, 259 4, 903		65. 00 66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	(0		67. 00 68. 00
70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	4, 004 0		4, 004 0		69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	114, 651		114, 651		71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	34, 873 34, 710	1	34, 873 34, 710	i e	72. 00 73. 00
74. 00		O	0	Č	0	i	74. 00
75. 00		0	0	(0		75. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		Ö		Ö		89. 00
90.00	I I	0	0		0		90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		246, 733	(246, 733		91. 00 92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	C	0		94. 00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		95. 00 96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0		o o		97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0		98. 00
	09900		0		0		99. 00 99. 10
100.0	0 10000 I&R SERVICES-NOT APPRVD PRGM		0		Ö		100. 00
101. 0	D 10100 HOME HEALTH AGENCY	0	0	() C	0		101. 00

	MANDAE 1106				6.5. 000 0550 10
Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	MONROE HOS	Provider CC	CN: 15-0183	Period:	u of Form CMS-2552-10 Worksheet B
				From 01/01/2016	Part II
				To 12/31/2016	Date/Time Prepared: 5/27/2017 10:46 am
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	
			Residents Cos	st	
			& Post Stepdown		
			Adjustments		
	17.00	24. 00	25. 00	26.00	
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	107. 00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION		0		0	108. 00 109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0			110.00
111. 00 11100 SLET ACQUI SI TI ON		0			111.00
113. 00 11300 NTEREST EXPENSE		Ĭ			113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	115. 00
116. 00 11600 HOSPI CE	0	0		0 0	116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 318, 909		0 1, 318, 909	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		٥			190. 00
191. 00 19100 RESEARCH		0			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	439, 763		0 439, 763	192. 00
193. 00 19300 NONPALD WORKERS	o	0		0 0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	О	О		0 0	194. 00
194.01 07951 PUBLIC RELATIONS/MARKETING	0	3, 492		0 3, 492	194. 01
200.00 Cross Foot Adjustments		0		0 0	200. 00
201.00 Negative Cost Centers	0	0		0 0	201. 00
202.00 TOTAL (sum lines 118-201)	0	1, 762, 164		0 1, 762, 164	202. 00

| Period: | Worksheet B-1 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Provi der CCN: 15-0183

					o 12/31/2016	Date/Time Prep 5/27/2017 10:4	
		CAPITAL REI	ATED COSTS			3/2//2017 10.	40 alli
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	oost denter bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Receiver Fraction	& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
12	GENERAL SERVICE COST CENTERS	1.00	2.00	4. 00	5A	5. 00	
	00100 CAP REL COSTS-BLDG & FIXT	100, 717					1. 00
	00200 CAP REL COSTS-MVBLE EQUIP		100, 717				2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 275 17, 748	1			20, 863, 386	4. 00 5. 00
	00700 OPERATION OF PLANT	2, 681	2, 681				7. 00
	00800 LAUNDRY & LINEN SERVICE	556	ł		_	92, 357	8. 00
	00900 HOUSEKEEPI NG 01000 DI ETARY	368 4, 632	ł			467, 977 521, 483	9. 00 10. 00
	01100 CAFETERI A	0	0	1	1	021,100	11. 00
	01300 NURSI NG ADMI NI STRATI ON	0	0	,		.,,	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 638 741	1, 638 741			359, 524 615, 271	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	225	ŀ				16. 00
	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	0	17. 00
	03000 ADULTS & PEDIATRICS	7, 527	7, 527	1, 190, 401	0	1, 890, 699	30. 00
	03100 INTENSIVE CARE UNIT	4, 782	1				31. 00
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	·	-	0	32. 00 33. 00
	03400 SURGICAL INTENSIVE CARE UNIT	0	0		-	0	34. 00
	04000 SUBPROVI DER - I PF	0	0	C	0	0	40. 00
	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0		0	0	41. 00 43. 00
	04400 SKILLED NURSING FACILITY	0	0		0	0	44. 00
	04500 NURSING FACILITY	0	0	C		0	45. 00
	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0		0	0	46. 00
	05000 OPERATING ROOM	11, 153	11, 153	1, 118, 171	0	2, 073, 933	50. 00
	05100 RECOVERY ROOM	0	0		-		51. 00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 131	0 131		-	0 2, 292	52. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	7, 163	ł		_	1, 705, 929	54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	0	C	-	0	55. 00
	05600 RADI 0I SOTOPE 05700 CT SCAN	468	0 468	20, 307	_	0 34, 906	56. 00 57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	464	464			76, 511	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	017 146		1 2/0 020	59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	2, 431 0	2, 431 0	817, 148		1, 260, 939 0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61. 00
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62. 00 63. 00
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0	0	64. 00
	06500 RESPIRATORY THERAPY	607	607			459, 888	65. 00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	121	121	l		139, 113	66. 00 67. 00
	06800 SPEECH PATHOLOGY	0	ő			Ö	68. 00
	06900 ELECTROCARDI OLOGY	0	0	129, 621	0	198, 053	69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,732	2, 732		0	0 2, 208, 576	70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o o	1, 674, 445	
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	608, 868	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0			0	74. 00 75. 00
	OUTPATIENT SERVICE COST CENTERS				,		70.00
	08800 RURAL HEALTH CLINIC	0	0	1		0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00 90. 00
	09100 EMERGENCY	10, 874	10, 874	1, 206, 876	0		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0	0			0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96. 00 97. 00
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(, 0	0	98.00
99. 00	09900 CMHC	0	Ō	C	-	0	99. 00
99. 10	09910 CORF	0	0		0	0	99. 10

			T	0 12/31/2016	Date/Time Prepare 5/27/2017 10:46 a	
	CAPITAL REL	ATED COSTS			0,27,2017 10.10	
Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation		
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT (GROSS		(ACCUM. COST)	
			SALARI ES)			
	1. 00	2.00	4. 00	5A	5. 00	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0			0 100	. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101	. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105	. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0 106	
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107	
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108	
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110	
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111	
113. 00 11300 I NTEREST EXPENSE					113	
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115	
116. 00 11600 HOSPI CE	70.047	0	0	(504 700	0 116	
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	78, 317	78, 317	10, 350, 535	-6, 591, 798	20, 273, 490 118	. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		<u> </u>		0	0 190	
191. 00 19100 RESEARCH		0	0	0	0 191	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	22, 376	22, 376	o n	0	391, 500 192	
193. 00 19300 NONPALD WORKERS	22, 370	22, 370	o n	0	0 193	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	o o	0	0 194	
194. 01 07951 PUBLIC RELATIONS/MARKETING	24	24	29, 843	0	198, 396 194	
200.00 Cross Foot Adjustments			,		200	
201.00 Negative Cost Centers					201	. 00
202.00 Cost to be allocated (per Wkst. B,	1, 698, 934	63, 230	3, 033, 767		6, 591, 798 202	. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part	16. 868394	0. 627799	0. 292260		0. 315951 203	
204.00 Cost to be allocated (per Wkst. B,			22, 307		313, 832 204	. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 002149		0. 015042 205	. 00
1)						

	Financial Systems LLOCATION - STATISTICAL BASIS	MONROE H	OSPITAL Provider Co	^N: 15_0193 E	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
C031 F	ELECTION - STATISTICAL BASIS		11 Ovi dei C	F	rom 01/01/2016	Date/Time Pre	narod:
						5/27/2017 10:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	
		(SQUARE FEET)	(POUNDS OF	(323/11/2 1221)	(MEXES SERVED)	(112 3)	
		7.00	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	7.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	79, 013					7. 00
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	556 368					8. 00 9. 00
10.00	01000 DI ETARY	4, 632		4, 632			10.00
11. 00	01100 CAFETERI A	0	0	C	9, 210	14, 221	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	1, 638	0	1, 638	0	687 0	13. 00 14. 00
15. 00	01500 PHARMACY	741		741		0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	225		225		495	
17. 00	O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	(0	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	7, 527	4, 075	7, 527	12, 134	2, 501	30.00
31. 00	03100 I NTENSI VE CARE UNI T	4, 782	983	4, 782	924	1, 330	
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0		0	0	32. 00 33. 00
	03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	C	o	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	(0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0			0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	Ō	d	O	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	(0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	11, 153	0	11, 153	O	2, 090	50.00
51. 00	05100 RECOVERY ROOM	0	Ö	(1	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(-	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	131 7, 163		131 7, 163		0 1, 280	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ō	(0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	(-	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	468 464	0	468 464		23 104	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö		1	0	59. 00
60.00	06000 LABORATORY	2, 431	0	2, 431	0	1, 433	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0	0	1		0	60. 01 61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	o	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	607	0	607	0	0 507	64. 00 65. 00
	06600 PHYSI CAL THERAPY	121	Ö	121		135	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0			0 179	
70. 00		Ö	ő		Ö	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 732	0	2, 732	0	528	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			0 583	
74. 00	07400 RENAL DIALYSIS	Ö	ő		Ö	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1 0	0		ol ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	ő		Ö	0	89. 00
90.00	09000 CLINIC	0	0	10.07	0	0	90.00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 874	0	10, 874	. 66	2, 346	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09400 HOME PROGRAM DI ALYSI S	0	0	(0	0	94.00
	O9500 AMBULANCE SERVI CES O9600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD		0			0	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
	09900	0	0			0	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0			0	100. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0)l o	0	101. 00

Health Financial Systems	MONROE H	OSPI TAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2016 o 12/31/2016	Date/Time Prep	orod.
			'	0 12/31/2010	5/27/2017 10: 4	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTE' S)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.00	8. 00	9. 00	10.00	11. 00	
SPECIAL PURPOSE COST CENTERS	1	1				
105. 00 10500 KI DNEY ACQUI SI TI ON				0		105.00
106. 00 10600 HEART ACQUISITION	C			0		106. 00 107. 00
107. 00 10700 LIVER ACQUISITION				0		
108. 00 10800 LUNG ACQUISITION						108.00
109. 00 10900 PANCREAS ACQUISITION						109.00
110. 00 11000 INTESTINAL ACQUISITION						110. 00 111. 00
111. 00 11100 SLET ACQUI SI TI ON			1	0		111.00
113. 00 11300 I NTEREST EXPENSE		•				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE						116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	56, 613	5, 058	55, 689	22, 334	14, 221 1	
NONREI MBURSABLE COST CENTERS	30,013	3,036	33, 009	22, 334	14, 221	116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					0 1	190. 00
191. 00 19100 RESEARCH						191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	22, 376		22, 376	5, 765		192.00
193. 00 19300 NONPALD WORKERS	22, 370		22,370	0, 700		193.00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS				o o		194. 00
194. 01 07951 PUBLIC RELATIONS/MARKETING	24		24	i o		194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 704, 232	133, 529	623, 772	823, 154	269, 805 2	
Part I)	1,701,202	100,02,	020,772	020, 101	207,000	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	21. 569008	26. 399565	7. 987962	29. 294779	18. 972294 2	203. 00
204.00 Cost to be allocated (per Wkst. B,	66, 760	11, 587	14, 399	94, 267	30, 898 2	
Part II)			1			
205.00 Unit cost multiplier (Wkst. B, Part	0. 844924	2. 290826	0. 184392	3. 354817	2. 172702	205. 00

	ALLOCATION - STATISTICAL BASIS	MONROL 110	Provider CO	CN: 15-0183	Peri od:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016	Date/Time Pre 5/27/2017 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	(TIME SPENT)	
		(DI RECT NURS.	(COSTED	KEQUI 3.)	(GROSS	(TIME SIENT)	
		HRS.)	REQUIS.)		REVENUE)		
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13. 00	01300 NURSING ADMINISTRATION	159, 283					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	2, 769, 645				14. 00
15. 00	01500 PHARMACY	0	0	1	00 0 132, 684, 836		15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	0		0 132, 684, 836	0	16. 00 17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		-				1
30.00	03000 ADULTS & PEDIATRICS	58, 086	0		0 5, 692, 468		
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	28, 687	0		0 1, 996, 368	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o	0		0 0	0	1
40. 00	04000 SUBPROVI DER - I PF	0	0		0 0	0	
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	0	0		0	0	
44. 00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	1
45. 00	04500 NURSING FACILITY	0	0		0 0	0	
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	46. 00
50. 00	05000 OPERATING ROOM	16, 558	0		0 21, 942, 087	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 1, 461, 076 0 6, 171, 210	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0, 171, 210	0	
56. 00	05600 RADI OI SOTOPE	0	0		0 0	0	
57. 00 58. 00	05700 CT SCAN	0	0		0 9, 080, 092	0	1
59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0		0 2, 053, 114	0	
60.00	06000 LABORATORY	5, 986	0		0 15, 013, 569		1
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0 3, 807, 201	0	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 653, 348	0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 521	0		0 1, 602, 871	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 2, 160, 777		0 19, 775, 764	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	608, 868		0 22, 173, 446	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	5, 962, 991	0	73. 00
74.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	
75.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	48, 445	0		0 15, 299, 231	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	40, 443	J		13, 277, 231		92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED		0		0 0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0		0 0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	•
99. 00 99. 10	09900 CMHC 09910 CORF	0	0		0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM		0		0 0	-	100.00
	10100 HOME HEALTH AGENCY	0	0	<u> </u>	0 0		101. 00

Health Financial Systems	MONROE HO	SPI TAL		In Lie	u of Form CMS-2552-	-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016	Date/Time Prepared	al.
				To 12/31/2016	5/27/2017 10: 46 an	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(DI RECT NURS.	(COSTED		(GROSS		
	HRS.)	REQUIS.)		REVENUE)		
	13. 00	14. 00	15. 00	16. 00	17. 00	
SPECIAL PURPOSE COST CENTERS		_1		_1		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0	0 105.	
106. 00 10600 HEART ACQUISITION	0	0		0	0 106.	
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	0 107.	
108. 00 10800 LUNG ACQUISITION	0	0		0	0 108.	
109. 00 10900 PANCREAS ACQUISITION	0	0		0	0 109.	
110. 00 11000 INTESTINAL ACQUISITION	0	0		0	0 110.	
111. 00 11100 SLET ACQUISITION	0	0		0	0 111.	
113. 00 11300 INTEREST EXPENSE					113.	
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0 115.	
116. 00 11600 HOSPI CE	150 000	0 7/0 /45	4.0	0	0 116.	
118. 00 SUBTOTALS (SUM OF LINES 1-117)	159, 283	2, 769, 645	10	0 132, 684, 836	0 118.	00
NONREI MBURSABLE COST CENTERS		ما		0 0	0.100	00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	U		0	0 190.	
191. 00 19100 RESEARCH	0	0		0	0 191.	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0	0 192.	
193. 00 19300 NONPALD WORKERS	0	U		0	0 193. 0 194.	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 194. 01 07951 PUBLIC RELATIONS/MARKETING	0	U		0	0 194.	
	٥	۷		U U	200.	
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers					200.	
	1, 846, 791	E21 E20	831, 56	8 409, 437	0 202.	
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 840, 791	521, 530	831, 50	8 409, 437	0 202.	00
203.00 Unit cost multiplier (Wkst. B, Part I)	11. 594401	0. 188302	8, 315. 68000	0. 003086	0. 000000 203.	00
204.00 Cost to be allocated (per Wkst. B,	24, 586	36, 101	23, 83		0.000000 203.	
Part II)	24, 300	30, 101	25, 05	10, 147	0 204.	50
205.00 Unit cost multiplier (Wkst. B, Part	0. 154354	0. 013035	238. 31000	0. 000076	0. 000000 205.	00
	1	2. 2.2000		1.2200.0		

Health Financial Systems	MONROE HO	OSPI TAL		In Li€	eu of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1, 00	2.00	3, 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 912, 074		3, 912, 07	4 O	3, 912, 074	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 854, 663		1, 854, 66	3 0	1, 854, 663	31.00
32. 00 03200 CORONARY CARE UNIT	0			0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		1	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0		1	0	0	40. 00
41. 00 04100 SUBPROVI DER - 1 RF	0			0	0	41.00
43. 00 04300 NURSERY	0			0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0			0	0	44. 00
45.00 04500 NURSING FACILITY	0			0	0	45. 00
46.00 O4600 OTHER LONG TERM CARE	0			0	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 358, 188		3, 358, 18	8 0	3, 358, 188	
51.00 05100 RECOVERY ROOM	0		1	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		1	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	11, 397		11, 39		11, 397	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 499, 965		2, 499, 96	5 0	2, 499, 965	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0			0	0	56. 00
57.00 05700 CT SCAN	88, 224		88, 22		88, 224	
EO OO OEOOO MACHETIC DESCNIANCE LMACING (MDI)	122 700		122 70	ol o	122 700	E0 00

Health Financial Systems	MONROE HO	SPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C	
				From 01/01/2016 To 12/31/2016	Part Date/Time Pre	pared:
					5/27/2017 10:	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
202.00 Total (see instructions)	25, 847, 948	0	25, 847, 94	18 0	25, 847, 948	202. 00

Health Financial Systems	MONROE HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0183	Peri od:	Worksheet C
		From 01/01/2016	Part I
		To 12/31/2016	Date/Time Prepared:
			5/27/2017 10:46 am
	T1 11 \0.0111		DDO

		Title	xVIII	Hospi tal	5/27/2017 10: PPS	46 am_
		Charges				
Cost Center Description	Inpatient	Outpati ent	lotal (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
			1 001. 77		Rati o	
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00 03000 ADULTS & PEDIATRICS	5, 473, 244		5, 473, 244			30.00
31.00 03100 INTENSIVE CARE UNIT	1, 996, 368		1, 996, 368			31. 00
32. 00 03200 CORONARY CARE UNIT	0		C			32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0					33. 00 34. 00
40. 00 04000 SUBPROVI DER - 1 PF						40.00
41. 00 04100 SUBPROVI DER - RF	o		C			41. 00
43. 00 04300 NURSERY	0		C			43.00
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	0					44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE	o o		ď			46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	8, 691, 393 0	13, 250, 694	21, 942, 087		0. 000000 0. 000000	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0		0.00000	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	689, 447	771, 629	1, 461, 076		0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	669, 086	5, 502, 124			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0	C	0. 000000 0. 000000	0. 000000 0. 000000	55. 00 56. 00
57. 00 05700 CT SCAN	1, 075, 857	8, 004, 235	9, 080, 092		0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	216, 138	1, 836, 976	2, 053, 114		0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0 520 404	12 472 005	15 012 540	0.000000	0.000000	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	2, 539, 684 0	12, 473, 885 0	15, 013, 569	0. 124828 0. 000000	0. 000000 0. 000000	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	o	0	ď	0. 000000	0. 000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0. 000000	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	0	C	0.000000	0.000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	2, 877, 461	929, 740	3, 807, 201	0. 000000 0. 169284	0. 000000 0. 000000	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	636, 842	16, 506			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0. 000000	0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 616, 594	986, 277	1, 602, 871	0. 000000 0. 178807	0. 000000 0. 000000	68. 00 69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	010, 394	980, 277	1,002,871	0. 000000	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 954, 161	10, 821, 603			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	17, 472, 552	4, 700, 894			0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	3, 246, 001	2, 716, 990 0	5, 962, 991		0. 000000 0. 000000	73. 00 74. 00
75.00 07500 ASC (NON-DISTINCT PART)	Ö	0	Č	0. 000000	0. 000000	75. 00
OUTPATIENT SERVICE COST CENTERS			1	.I		
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				88. 00 89. 00
90. 00 09000 CLI NI C	0	0		0. 000000	0. 000000	1
91. 00 09100 EMERGENCY	1, 537, 564	13, 761, 667	15, 299, 231	0. 228145	0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 000	209, 224	219, 224	0. 588626	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	O	0		0. 000000	0. 000000	94.00
95. 00 09500 AMBULANCE SERVICES	o	0	C	0. 000000	0. 000000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0.000000	0. 000000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0. 000000 0. 000000	0. 000000 0. 000000	97. 00 98. 00
99. 00 09900 CMHC	0	0		0.000000	0.00000	99.00
99. 10 09910 CORF	o	0	C			99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0				100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	C			101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	O	0	С)		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	C			106. 00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0	C			107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION		0				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	ď			110. 00
111. 00 11100 SLET ACQUISITION	0	0	C			111.00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	c			115. 00
116. 00 11600 HOSPI CE	0	0	C			116. 00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	56, 702, 392	75, 982, 444	132, 684, 836			200. 00 201. 00
201.00 Less Observation Beds 202.00 Total (see instructions)	56, 702, 392	75, 982, 444	132, 684, 836			201.00
			, , , , , , , , , ,	1	i	

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES MONROE HOSPITAL Provider CCN: 15-0183

Title XVIII

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32. 00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - 1 PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
45.00 04500 NURSING FACILITY				45. 00
46.00 04600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 153048			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 007800			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 405101			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 009716			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 059767			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 124828			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
	1			
	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 169284			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 292677			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 178807			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 175217			71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0. 107630			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 278765			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 228145			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 588626			92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00
106. 00 10600 HEART ACQUI SI TI ON				106. 00
107. 00 10700 LI VER ACQUI SI TI ON				107. 00
108. 00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION				110. 00 111. 00
113. 00 11300 I NTEREST EXPENSE				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 499, 965 2, 499, 965 0 2, 499, 965 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 57. 00 05700 CT SCAN 88, 224 88, 224 0 88, 224 0 88, 224 0 122, 708 0 0 0 0 0 0 0 0 122, 708 0 122, 708 0 122, 708 0	074 30.00 663 31.00 0 32.00 0 33.00 0 34.00 0 40.00 0 41.00 0 43.00 0 44.00 0 45.00 0 46.00 188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00
Total Cost Cost Center Description	074 30.00 663 31.00 0 32.00 0 33.00 0 40.00 0 41.00 0 44.00 0 45.00 0 45.00 0 46.00 188 50.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
INPATI ENT ROUTINE SERVICE COST CENTERS 3,912,074	663 31.00 0 32.00 0 33.00 0 34.00 0 40.00 0 41.00 0 43.00 0 44.00 0 45.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
30. 00	663 31.00 0 32.00 0 33.00 0 34.00 0 40.00 0 41.00 0 43.00 0 44.00 0 45.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
31.00 03100 NTENSI VE CARE UNI T 1,854,663 1,854,663 0 1,854, 633 0 1,854, 633 0 0 0 0 0 0 0 0 0	663 31.00 0 32.00 0 33.00 0 34.00 0 40.00 0 41.00 0 43.00 0 44.00 0 45.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
33.00 03300 BURN I INTENSI VE CARE UNIT 0 0 0 0 34.00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 0 41.00 04400 SUBROVIDER - IPF 0 0 0 0 41.00 04400 SUBROVIDER - IRF 0 0 0 0 43.00 04300 SUBROVIDER - IRF 0 0 0 0 44.00 04400 SUBROVIDER - IRF 0 0 0 0 45.00 04400 SKI LLED NURSI NG FACILITY 0 0 0 0 46.00 04400 SKI LLED NURSI NG FACILITY 0 0 0 0 46.00 04500 NURSI NG FACILITY 0 0 0 0 46.00 04500 NURSI NG FACILITY 0 0 0 0 47.00 04500 OURSI NG FACILITY 0 0 0 0 48.00 04500 OURSI NG FACILITY 0 0 0 0 49.00 05500 OURSI NG FACILITY 0 0 0 0 40.00 05000 OPERATI NG ROOM 0 0 0 40.00 05000 OES200 DELI VERY ROOM & LABOR ROOM 0 0 0 40.00 05400 RADI OLOGY-DI AGNOSTI C 2,499,965 2,499,965 0,2499,965 0,	0 33.00 0 34.00 0 40.00 0 41.00 0 43.00 0 45.00 0 46.00 188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 34.00 0 40.00 0 41.00 0 43.00 0 44.00 0 45.00 0 46.00 188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
40.00 04000 SUBPROVI DER - I PF	0 41.00 0 43.00 0 44.00 0 45.00 0 46.00 188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 62.00 0 63.00
43. 00 04300 NURSERY 0 0 04400 SKI LLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 43.00 0 44.00 0 45.00 0 46.00 188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 56.00 0 56.00 0 56.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
44. 00	0 44.00 0 45.00 0 46.00 188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
45. 00	0 45.00 0 46.00 188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
ANCILLARY SERVICE COST CENTERS	188 50.00 0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
50. 00 05000 OPERATI NG ROOM OFERATI NG	0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
51. 00 05100 RECOVERY ROOM 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 11, 397 0 <td< td=""><td>0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00</td></td<>	0 51.00 0 52.00 397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
53. 00 05300 ANESTHESI OLOGY 11, 397 11, 397 0 11, 397 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 499, 965 2, 499, 965 0 2, 499, 965 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 05600 RADI OI SOTOPE 0 0 0 0 57. 00 05700 CT SCAN 88, 224 88, 224 0 88, 254 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 122, 708 122, 708 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60. 00 06000 LABORATORY 1, 874, 110 1, 874, 110 1, 874, 110 0 1, 874, 110 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0	397 53.00 965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 499, 965 2, 499, 965 0 2, 499, 965 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 57. 00 05700 CT SCAN 88, 224 88, 224 0 88, 224 0 88, 224 0 88, 224 0 88, 224 0	965 54.00 0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 88, 224 88, 224 88, 224 0 88, 224 0 88, 224 0 88, 224 0 88, 224 0 1, 874, 110 0 1, 874, 110 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td>0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00</td></td<>	0 55.00 0 56.00 224 57.00 708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
57. 00 05700 CT SCAN 88, 224 88, 224 0 88, 224 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 122, 708 122, 708 0 122, 708 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 1, 874, 110 1, 874, 110 0 1, 874, 110 0 60. 01 06001 BLOOD LABORATORY 0<	224 57. 00 708 58. 00 0 59. 00 110 60. 00 0 60. 01 0 61. 00 0 62. 00 0 63. 00
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 122, 708 122, 708 0 122, 708 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 1, 874, 110 1, 874, 110 0 1, 874, 110 60. 01 06001 BLOOD LABORATORY 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 644, 499 0 644, 499 0 66. 00 06600 PHYSI CAL THERAPY 191, 220 0 191, 220 0 191, 220 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0	708 58.00 0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60. 00 06000 LABORATORY 1,874,110 1,874,110 0 1,874,110 0 60. 01 06001 BLOOD LABORATORY 0	0 59.00 110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
60. 00 06000 LABORATORY 1,874,110 1,874,110 0 1,874, 110 0 0 0 0 0 0 0 0 0	110 60.00 0 60.01 0 61.00 0 62.00 0 63.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 0 0	0 61.00 0 62.00 0 63.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0	0 62.00 0 63.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0	0 63.00
65. 00 06500 RESPIRATORY THERAPY 644, 499 0 644, 499 0 644, 499 0 644, 499 66. 00 06600 PHYSI CAL THERAPY 191, 220 0 191, 220 0 191, 220 0 191, 220 0 0 0 0 0 0 0 0 0	0 64 00
66. 00 06600 PHYSI CAL THERAPY 191, 220 0 191, 220 0 191, 220 0 191, 220 0 0 0 0 0 0 0 0 0	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0	
	0 67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 286, 605 286, 605 0 286,	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 3, 465, 042 3, 465, 042 0 3, 465, 042	0 70.00 042 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 2, 386, 539 2, 386, 539 0 2, 386,	539 72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 1, 662, 271 1, 662, 271 0 1, 662, 271 0 1, 662, 271 0 0 0 0 0 0 0 0 0	
74. 00 07400 RENAL DI ALYSI S	0 74.00 0 75.00
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0	0 88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 89.00 0 90.00
91. 00 09100 EMERGENCY 3, 490, 443 3, 490, 443 0 3, 490,	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 129, 041 129, 041 129,	041 92.00
OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0	0 94.00
95. 00 09500 AMBULANCE SERVI CES 0 0	0 95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0	0 96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0	0 97.00 0 98.00
99. 00 09900 CMHC 0 0	0 99.00
99. 10 09910 CORF 0 0	0 99. 10
100.00 10000 L&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 100. 00 0 101. 00
SPECIAL PURPOSE COST CENTERS	0101.00
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0	0 105. 00
106. 00 10600 HEART ACQUI SI TI ON	0 106. 00 0 107. 00
108. 00 10800 LUNG ACQUI SI TI ON 0 0	0 108. 00
109. 00 10900 PANCREAS ACQUISITION 0 0	0 109. 00
110. 00 11000 INTESTINAL ACQUISITION 0 0	0 110.00
111. 00 11100 I SLET ACQUI SI TI ON	0 111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	114. 00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0	0 115. 00
116.00 11600 HOSPICE 0 0 0 25, 976, 989 0 25, 976, 989 0 25, 976, 989 0 25, 976, 989	0 116. 00 989 200. 00
	041 201. 00

Health Financial Systems	MONROE H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre	nared:
				10 12/31/2010	5/27/2017 10:	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
202 00 Total (see instructions)	25 847 948	0	25 847 94	8 0	25 847 948	202 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | 5/27/2017 10:46 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0183

				Titl	e XIX	Hospi tal	5/27/2017 10: PPS	46 am_
				Charges			TEED.	
		Cost Center Description	Inpatient	Outpati ent	lotal (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
				7.00	<u> </u>		Rati o	
Г	NPAT	ENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30.00	03000	ADULTS & PEDI ATRI CS	5, 473, 244		5, 473, 244			30. 00
		INTENSIVE CARE UNIT	1, 996, 368		1, 996, 368			31.00
		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0)		32. 00 33. 00
		SURGICAL INTENSIVE CARE UNIT	o					34. 00
		SUBPROVI DER - I PF	0		C)		40. 00
		SUBPROVI DER – I RF NURSERY	0)		41. 00 43. 00
		SKILLED NURSING FACILITY	0					44. 00
45. 00 C	04500	NURSING FACILITY	o		C			45. 00
46. 00 C	04600 MCLLI	OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0)		46. 00
50.00	05000	OPERATING ROOM	8, 691, 393	13, 250, 694	21, 942, 087	0. 153048	0. 000000	50. 00
		RECOVERY ROOM	0	0	(0. 000000	
		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	689, 447	771, 629	1, 461, 07 <i>6</i>	0. 000000 0. 007800	0. 000000 0. 000000	
		RADI OLOGY-DI AGNOSTI C	669, 086	5, 502, 124			0. 000000	
		RADI OLOGY-THERAPEUTI C	o	0			0. 000000	
		RADI OI SOTOPE CT SCAN	0 1, 075, 857	0 8, 004, 235	9, 080, 092	0.00000	0. 000000 0. 000000	
		MAGNETIC RESONANCE IMAGING (MRI)	216, 138	1, 836, 976	2, 053, 114		0. 000000	
59.00	05900	CARDI AC CATHETERI ZATI ON	О	0	C	0. 000000	0. 000000	59. 00
		LABORATORY	2, 539, 684	12, 473, 885	15, 013, 569		0.000000	
		BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	(0. 000000 0. 000000	0. 000000 0. 000000	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	Ö	Č	0. 000000	0. 000000	
		BLOOD STORING, PROCESSING & TRANS.	0	0	C	0. 000000	0. 000000	
		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0 2, 877, 461	0 929, 740	3, 807, 201	0. 000000 0. 169284	0. 000000 0. 000000	
		PHYSI CAL THERAPY	636, 842	16, 506			0. 000000	
		OCCUPATI ONAL THERAPY	O	0	C	0.00000	0. 000000	
		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0 616, 594	986, 277	1, 602, 871	0. 000000 0. 178807	0. 000000 0. 000000	
		ELECTROCARDIOLOGI	010, 394	960, 277	1,002,671	0. 178807	0. 000000	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 954, 161	10, 821, 603	19, 775, 764	0. 175217	0. 000000	
		IMPL. DEV. CHARGED TO PATIENTS	17, 472, 552	4, 700, 894			0.000000	
		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	3, 246, 001 0	2, 716, 990 0			0. 000000 0. 000000	
75. 00 C	07500	ASC (NON-DISTINCT PART)	Ō	0			0. 000000	
		TIENT SERVICE COST CENTERS	ما			0.000000	0.000000	00.00
		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
90.00		CLI NI C	o	0	C	0. 000000	0. 000000	90. 00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	1, 537, 564	13, 761, 667 209, 224			0. 000000 0. 000000	
		REIMBURSABLE COST CENTERS	10, 000	207, 224	217, 22-	0. 300020	0.00000	72.00
		HOME PROGRAM DI ALYSI S	0	0	C	0.000000	0.000000	1
		AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	0	0		0. 000000 0. 000000	0. 000000 0. 000000	1
		DURABLE MEDICAL EQUIP-SOLD	o	0		0. 000000	0. 000000	
		OTHER REIMBURSABLE COST CENTERS	0	0	C	0. 000000	0. 000000	1
	09900 09910		0	0)		99. 00 99. 10
1		I&R SERVICES-NOT APPRVD PRGM	o	0				100.00
		HOME HEALTH AGENCY	0	0	C)		101. 00
		AL PURPOSE COST CENTERS KIDNEY ACQUISITION	ol	0				105. 00
		HEART ACQUISITION	Ö	Ö	Č			106. 00
1		LIVER ACQUISITION	0	0	(107. 00
1		LUNG ACQUISITION PANCREAS ACQUISITION	0	0)		108. 00 109. 00
		INTESTINAL ACQUISITION	o	0				110. 00
1		I SLET ACQUI SI TI ON	o	0	C			111. 00
		INTEREST EXPENSE UTILIZATION REVIEW-SNF						113. 00 114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	О	0				115. 00
116. 00 1		HOSPI CE	0	0	(116. 00
200. 00 201. 00		Subtotal (see instructions) Less Observation Beds	56, 702, 392	75, 982, 444	132, 684, 83 <i>6</i>			200. 00 201. 00
202.00		Total (see instructions)	56, 702, 392	75, 982, 444	132, 684, 836			202. 00
			'					

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES MONROE HOSPITAL Provider CCN: 15-0183

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 01/01/2016 | Part | | To 12/31/2016 | Date/Time Prepared: | 5/27/2017 10: 46 am | Post of the control of the

		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT				33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF				40.00
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43. 00
44. 00 04400 SKI LLED NURSING FACILITY				44. 00
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE				45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS				10.00
50. 00 05000 OPERATING ROOM	0. 153048			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 000000 0. 007800			52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 405101			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 009716			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0. 059767 0. 000000			58. 00 59. 00
60. 00 06000 LABORATORY	0. 124828			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0.000000			63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000 0. 169284			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 292677			66. 00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0.000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 178807			69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000 0. 175217			70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 107630			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 278765			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74. 00
75. 00 O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0. 000000			75. 00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 228145			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 588626			92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			94, 00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC	0. 000000			98. 00 99. 00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				105.00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION				105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON				107. 00
108. 00 10800 LUNG ACQUI SI TI ON				108. 00
109.00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110. 00
111. 00 11100 SLET ACQUISITION				111.00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF				113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)	ı			202. 00

Peri od: Worksheet C From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared: 5/27/2017 10: 46 am Provi der CCN: 15-0183 REDUCTIONS FOR MEDICALD ONLY

					5/27/2017 10:	46 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
		Í	col . 2)			
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 358, 188	248, 979	3, 109, 209	0	0	50.00
51.00 05100 RECOVERY ROOM	0	(0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	11, 397	2, 572	8, 825	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 499, 965	163, 119	2, 336, 846	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(ol ol	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	(ol ol	0	0	56. 00
57. 00 05700 CT SCAN	88, 224	9, 978	78, 246	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	122, 708	10, 243	112, 465	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(ol o	0	0	59. 00
60. 00 06000 LABORATORY	1, 874, 110	70, 936	1, 803, 174	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	(0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	1	ol ol	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1	ol ol	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0	0	0	63. 00
64. 00 06400 NTRAVENOUS THERAPY	0	(0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	644, 499	20, 259	624, 240	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	191, 220	1		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	286, 605	4, 004	282, 601	0	o o	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	., 55	0	0	o o	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 465, 042	114, 651	3, 350, 391	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 386, 539			0	o o	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 662, 271	34, 710		0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	(o	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	ď	o	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u>'</u>		<u> </u>	
88. 00 08800 RURAL HEALTH CLINIC	0	(0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(o	0	0	89. 00
90. 00 09000 CLI NI C	0	(o	0	0	90.00
91. 00 09100 EMERGENCY	3, 490, 443	246, 733	3, 243, 710	0	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	129, 041	7, 762	121, 279	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	(0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	(0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	(0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	(0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	(0	0	0	98. 00
99. 00 09900 CMHC	0	(0	0	0	99. 00
99. 10 09910 CORF	0	(0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	(0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	(0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	(0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	(0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	(0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	(0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	(0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	(0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	(0	0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(0		115. 00
116. 00 11600 HOSPI CE	0	(0	0		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	20, 210, 252	1		0		200. 00
201. 00 Less Observation Beds	129, 041	7, 762		0		201. 00
202.00 Total (line 200 minus line 201)	20, 081, 211	965, 960	19, 115, 251	0	1 0	202. 00

Peri od: Worksheet C From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared: 5/27/2017 10: 46 am REDUCTIONS FOR MEDICALD ONLY

		-	VI.V		5/27/2017 10:	<u>.46 am</u>
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge			
	Operating Cost	Part I, column	Ratio (col. 6			
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS	•					
50. 00 05000 OPERATI NG ROOM	3, 358, 188	21, 942, 087	0. 153048			50.00
51. 00 05100 RECOVERY ROOM	0,000,100	21,712,007	0. 000000			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 000000			52. 00
1 I	11 207	1 4/1 07/				•
53. 00 05300 ANESTHESI OLOGY	11, 397					53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 499, 965	6, 171, 210				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0.000000			56. 00
57.00 05700 CT SCAN	88, 224	9, 080, 092	0.009716			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	122, 708	2, 053, 114	0. 059767			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0	0.000000			59. 00
60. 00 06000 LABORATORY	1, 874, 110	15, 013, 569				60.00
60. 01 06001 BLOOD LABORATORY	1,07.1,1.10	10,010,007	0.000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000			61. 00
						1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0.000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		1 0	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	644, 499	3, 807, 201	0. 169284			65. 00
66. 00 06600 PHYSI CAL THERAPY	191, 220	653, 348	0. 292677			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	286, 605	1, 602, 871				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	200,000	1,002,071	0. 000000			70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 465, 042	19, 775, 764				71.00
	1					1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	2, 386, 539					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 662, 271					73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000			89. 00
90. 00 09000 CLI NI C	0	0	0.000000			90.00
91. 00 09100 EMERGENCY	3, 490, 443	15, 299, 231	0. 228145			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	129, 041					92.00
OTHER REIMBURSABLE COST CENTERS	1277011	2.7722.	0.000020			1 /2:00
94. 00 09400 HOME PROGRAM DI ALYSI S	0		0. 000000			94. 00
95. 00 09500 AMBULANCE SERVICES			0.00000			95. 00
						1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0.000000			96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.000000			97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 000000			98. 00
99. 00 09900 CMHC	0	0	0.000000			99. 00
99. 10 09910 CORF	0	0	0.000000			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0.000000			100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0.000000			101.00
SPECIAL PURPOSE COST CENTERS	•					
105. 00 10500 KIDNEY ACQUISITION	0	0	0. 000000			105. 00
106. 00 10600 HEART ACQUISITION		Ö				106. 00
107. 00 10700 LIVER ACQUISITION			0.00000			107. 00
108. 00 10800 LUNG ACQUISITION		0	0.000000			108. 00
109. 00 10900 PANCREAS ACQUISITION		1 0	0.000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0. 000000			110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0. 000000			111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0. 000000			115. 00
116. 00 11600 HOSPI CE	1	n	0. 000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	20, 210, 252	125, 215, 224	•			200. 00
201. 00 Less Observation Beds	129, 041					201. 00
202.00 Total (line 200 minus line 201)	20, 081, 211					202.00
202.00 10tal (1116 200 IIII III 3 1116 201)	20,001,211	120, 210, 224	1			1202.00

Health Financial Systems	MONROE HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 5/27/2017 10:46 am	
				Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		3 / col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SURGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30-199) Cost Center Description	235, 313 117, 636 0 0 0 0 0 0 0 0 352, 949 Inpatient Program days		235, 31 117, 63 352, 94	36 983 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 84 119. 67 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00
	6, 00	7. 00	-			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SURGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30-199)	2, 312 139 0 0 0 0 0 0 0 0 0 0	16, 634 0 0 0 0 0 0 0				30.00 31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00 200.00

Health Financial Systems	MONROE HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der CO	CN: 15-0183	Peri od:	Worksheet D	
				From 01/01/2016	Part II	
				To 12/31/2016		
		Title	xVIII	Hospi tal	5/27/2017 10: PPS	46 am_
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		column 4)	
	Part II, col.	8)	2)	. Orial ges	corumit 1)	
	26)	9)				
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATING ROOM	248, 979	21, 942, 087	0. 01134	7 4, 155, 174	47, 149	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	2, 572	1, 461, 076	0. 00176	0 354, 597	624	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	163, 119	6, 171, 210	0. 02643	2 407, 248	10, 764	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000		0	56. 00
57. 00 05700 CT SCAN	9, 978	9, 080, 092			785	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 243	2, 053, 114			538	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59. 00
60. 00 06000 LABORATORY	70, 936	15, 013, 569			7, 714	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ŭ	0.0000		Ü	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000		0	64. 00
65. 00 06500 RESPIRATORY THERAPY	20, 259	3, 807, 201	0. 00532		8, 507	65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 903	653, 348			2, 687	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	000,010	0. 00000		2, 667	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4,004	1, 602, 871	0. 00249		821	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1,004	1,002,071	0.00000		0.21	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	114, 651	19, 775, 764			22, 775	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	34, 873	22, 173, 446			14, 702	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	34, 710	5, 962, 991	0. 00582		9, 552	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0, 702, 771	1		0, 332	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
OUTPATIENT SERVICE COST CENTERS		0	0.00000	.0		73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000		0	89. 00
90. 00 09000 CLI NI C	0	0	0. 00000		0	90.00
91. 00 09100 EMERGENCY	246, 733	15, 299, 231	0. 01612		11, 041	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 762	219, 224			134	92. 00
OTHER REIMBURSABLE COST CENTERS	1,102	217, 224	0.03340	3, 770	134	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0	3.00000		O	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	n	n	0. 00000	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	n	0. 00000		0	98. 00
200.00 Total (lines 50-199)	973, 722	125, 215, 224		25, 261, 010	-	

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34.00

40.00

41.00

43.00

44.00

45.00

200. 00

34.00

200.00

03400 SURGICAL INTENSIVE CARE UNIT

Total (lines 30-199)

40. 00 | 04000 | SUBPROVI DER - I PF

41. 00 |04100 | SUBPROVI DER - I RF

45.00 04500 NURSING FACILITY

44.00 04400 SKILLED NURSING FACILITY

43. 00 | 04300 NURSERY

				Т	o 12/31/2016	Date/Time Pre 5/27/2017 10:	
			Ti tl e	e XVIII	Hospi tal	PPS	40 diii
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
	·	Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1	1		1	1	
50. 00	05000 OPERATI NG ROOM	0	0	ή	0	0	00.00
51. 00	05100 RECOVERY ROOM	0	0) C	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	02.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0) C	0	0	56. 00
57. 00	05700 CT SCAN	0	0) C	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0) C	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0) C	0	0	59. 00
60.00	06000 LABORATORY	0	0) C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) c	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
	07400 RENAL DIALYSIS	0	0) c	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	l c	o	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	O) C	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	o	0	0	89. 00
90.00	09000 CLI NI C	0	l c	o	0	0	90.00
91.00	09100 EMERGENCY	0	l c	o	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	ol c	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	•					1
94.00	09400 HOME PROGRAM DIALYSIS	0	C	0	0	0	94.00
95.00	09500 AMBULANCE SERVI CES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	o c	0	0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	o c) c	0	0	98. 00
200.00	1 1	0	o c	o c	0	0	200.00
		•	'	'	1	'	

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0183	
THROUGH COSTS		From 01/01/2016 Part IV

Title Will Signature Cost Center Description Total Outpatient Cross (Sum of Cost (THROUG	H COSTS				-rom 01/01/2016 Fo 12/31/2016		
ANCILLARY SERVICE COST CENTERS				Title	e XVIII	Hospi tal		40 diii
COST_(SUM_ of Col. 2, 3 and A)		Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
Col. 2, 3 and 8 8 77 Col. 6 + "col. 7		·	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
ANCILLARY SERVICE COST CENTERS			Cost (sum of	Part I, col.	(col. 5 + col.	to Charges	Charges	
ANCILLARY SERVICE COST CENTERS			col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
ANCILLARY SERVICE COST CENTERS 50.00 500.00 0 0 0 0 0 0 0 0			4)					
50.00 05000 05000 05000 050000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000			6. 00	7. 00	8. 00	9. 00	10.00	
51.00								
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0			1					
53.00 05300 ADSTHESI OLOGY 0		l	•		1		-	1
54.00 05400 RADI DLOGY-DI AGNOSTIC 0 6,171,210 0.000000 0.000000 407,248 54.00 55.00 05500 ADI DLOGY-THERAPEUTIC 0 0 0 0.000000 0.000000 0.55.00 55.00 05500 RADI DLOGY-THERAPEUTIC 0 0 0 0.000000 0.000000 0.56.00 55.00 05500 CT SCAN 0 9,080,092 0.000000 0.000000 714,384 57.00 0.000000 0.000000 714,384 57.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.59.00 0.000000 0.000000 0.000000 0.000000 0.59.00 0.000000 0.000000 0.000000 0.59.00 0.000000 0.000000 0.000000 0.59.00 0.000000 0.000000 0.000000 0.59.00 0.000000			-	1	1		_	1
55.00 05500 RADIO LOCY-THERAPEUTIC		l	-					
55.00 05500 ABJO I SOTOPE 0 0 0 0 0 0 0 0 0		l	0					
57.00 05700 CT SCAN 0 0 9,080,092 0.000000 0.000000 714,384 57.00 05800 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 2,053,114 0.000000 0.000000 107,906 58.00 05900 CARDIAC CATHETERIZATION 0 0 0.000000 0.000000 0.000000 0.59.00 0.000000 0.000000 0.000000 0.59.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000		l	0	0			_	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 2,053,114 0.000000 0.000000 107,906 58.00 05900 CARDIAC CATHETERI ZATION 0 0.000000 0.000000 0.000000 0.59.00 0.00000		1	0	0	1		_	1
59, 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0.000000 0.000000 0			_				·	
60. 00 06000 LABORATORY 0 15, 013, 569 0, 000000 0, 000000 1, 632, 547 60, 00 00 00 00 00 00 00					1			1
60.01 06.001 BLOOD LABDRATORY 0 0 0 0 0 0 0 0 0					1			1
61. 00 06100 PBP CLINICAL LAB SERVICES-PROM ONLY								
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0			0	0	0.00000	0. 000000	01	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0.000000 0.000000 0.000000 0.64. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0.000000 0.000000 0.000000 0.64. 00 65. 00 06500 RSPIRATORY THERAPY 0 3,807,201 0.000000 0.000000 1,598,738 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 653,348 0.000000 0.000000 358,072 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0.000000 0.000000 0.000000 0.67. 00 68. 00 06800 SPECEH PATHOLOGY 0 0.000000 0.000000 0.000000 0.68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1,602,871 0.000000 0.000000 0.000000 0.000000 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0.000000 0.000000 0.70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 19,775,764 0.000000 0.000000 3,288,618 69. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 19,775,764 0.000000 0.000000 9,346,230 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 5,962,991 0.000000 0.000000 1,640,909 73. 00 75. 00 07400 RENAL DI ALYSIS 0 0.000000 0.000000 0.000000 0.74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.0000							,	1
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0.000000 0.000000 0			0	1	1		-	
65. 00 06500 RESPIRATORY THERAPY 0 3,807,201 0.000000 0.000000 1,598,738 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 653,348 0.000000 0.000000 358,072 66. 00 67. 00 06700 0000000 0.0				ı	1		-	
66.00 06600 PHYSI CAL THERAPY 0 653, 348 0.000000 0.000000 358, 072 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0.000000 0.000000 0.67.00 68.00 SPEECH PATHOLOGY 0 0.000000 0.000000 0.000000 0.000000 0.000000		l l	-	1	1		_	
67. 00			-	-,,	1			
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0		l	-	1	1			1
69. 00 06900 ELECTROCARDI OLOGY 0 1, 602, 871 0.000000 0.000000 328, 618 69. 00 700. 00 70000 ELECTROENCEPHALLOGRAPHY 0 0 0.000000 0.000000 0.000000 0.70. 00 70. 00 70. 00 70. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 19, 775, 764 0.000000 0.000000 9, 346, 230 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 0 22, 173, 446 0.000000 0.000000 9, 346, 230 72. 00 73. 00 73. 00 73.00 DRUGS CHARGED TO PATI ENTS 0 5, 962, 991 0.000000 0.000000 1, 640, 909 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00 0.00000 0.000000 0.000000 0.000000 0.000000		l	-	1	1		-	
70.00		l	-	1	1			
71. 00			0	1, 602, 871				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 22, 173, 446 0.000000 0.000000 9, 346, 230 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 5, 962, 991 0.000000 0.000000 1, 640, 909 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0.000000 0.000000 0.000000 0.74. 00 075.		l I	0	0	1		-	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 5, 962, 991 0.000000 0.000000 1, 640, 909 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0.000000 0.000000 0.74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 0.000000 0.75. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0.88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 0.000000 0.89. 00 90. 00 09000 CLINIC 0 0 0.000000 0.000000 0.000000 0.90. 00 91. 00 09100 EMERGENCY 0 15, 299, 231 0.000000 0.000000 0.000000 684, 634 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 219, 224 0.000000 0.000000 3, 790 074. 00 09400 HOME PROGRAM DIALYSIS 0 0 0.000000 0.000000 0.000000 0.000000		l I						
74. 00 07400 RENAL DI ALYSI S 0 0 0.000000 0.000000 0.74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0.000000 0.000000 0.75. 00 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0.000000 0.000000 0.000000 0.89. 00 99. 00 09000 CLI NI C 0 0.000000 0.000000 0.000000 0.90. 00 91. 00 09100 EMERGENCY 0 15, 299, 231 0.000000 0.000000 0.000000 0.90. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 219, 224 0.000000 0.000000 3, 790 94. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0.000000 0.000000 0.90. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0.000000 0.000000 0.000000 0.90. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS		l I	-		1			
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 0 75. 00		l	1		l .			1
SERVICE COST CENTERS		l			1		_	
88. 00	75. 00		0	0	0.00000	0. 000000	. 0	75. 00
89. 00	00.00		1			0.00000		00.00
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0		l	_	-	1		-	
91. 00 09100 EMERGENCY 0 15, 299, 231 0. 000000 0. 000000 684, 634 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 219, 224 0. 000000 0. 000000 3, 790 92. 00 OP400 HOME PROGRAM DI ALYSI S 0 0 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0							-	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 219, 224 0.000000 0.000000 3, 790 92. 00		l			1		_	
OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSIS 0 0.000000 0.000000 0.94.00 95.00 09500 AMBULANCE SERVICES 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0.000000 0.96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0.000000 0.97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0.000000 0.98.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0.000000 0.98.00 99.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000		1			1		·	
94. 00	92.00		0	219, 224	0.00000	0. 000000	3, 790	92.00
95. 00 09500 AMBULANCE SERVI CES 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0.000000 0.000000 0.000000 0.96.00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0.000000 0.000000 0.000000 0.97.00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0.000000 0.000000 0.000000 0.98.00	04.00		1 0		0.00000	0.000000		04.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0.000000 0.000000 0.000000 0.97. 00 097. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000			0	0	0.00000	0.000000	ال	1 ,
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0.000000 0.000000 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0.000000 0.000000 0.000000 0					0.00000	0 000000		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0.000000 0 98. 00			_	· -			ŭ	
			-		l .		01	
200. 00				125 245 224	1	ا ٥٠ ٥٠٥٥٥٥	01	
	200.00		1 0	125, 215, 224	1	1	25, 261, 010	J∠UU. UU

Peri od: Worksheet D
From 01/01/2016 Part IV
To 12/31/2016 Date/Time Prepared: 5/27/2017 10: 46 am THROUGH COSTS

						5/27/2017 10: 46	am_
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	· ·	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	1		
		Costs (col. 8	3	Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM	0	3, 278, 950		0	F	50. 00
	05100 RECOVERY ROOM		0, 270, 700	1	o		51. 00
	05200 DELIVERY ROOM & LABOR ROOM		0	1	Ö	•	52. 00
	05300 ANESTHESI OLOGY		208, 016		Ö		53. 00
	05400 RADI OLOGY-DI AGNOSTI C		937, 471	•		l l	54. 00
	•		937, 471	1	0	·	
	05500 RADI OLOGY-THERAPEUTI C	0	-		0		55. 00
	05600 RADI OI SOTOPE	0	0		0		56. 00
	05700 CT SCAN	0	2, 044, 896		0		57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	715, 552		0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
	06000 LABORATORY	0	628, 016		0	l	60. 00
60. 01	06001 BLOOD LABORATORY	0	0		0	6	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					6	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	6	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	1 6	63. 00
	06400 I NTRAVENOUS THERAPY	0	0		0	16	64. 00
	06500 RESPI RATORY THERAPY	0	83, 792		0		65. 00
	06600 PHYSI CAL THERAPY	0	1, 551		0		66. 00
	06700 OCCUPATI ONAL THERAPY		0,001	1	Ö		67. 00
	06800 SPEECH PATHOLOGY		0		0	•	57. 00 58. 00
	06900 ELECTROCARDI OLOGY		593, 339		0		59. 00 59. 00
	07000 ELECTROEARD OLOGT		373, 337	1	0	•	70. 00
	•		2, 240, 649	l .	0	•	71. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			•	0	•	
	07200 MPL. DEV. CHARGED TO PATIENTS	0	675, 667		0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 129, 536		0		73. 00
	07400 RENAL DI ALYSI S	0	0		0		74. 00
	07500 ASC (NON-DISTINCT PART)	0	0		0	/	75. 00
	OUTPATIENT SERVICE COST CENTERS			1	_T		
	08800 RURAL HEALTH CLINIC	0	0		0		38. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	8	39. 00
90. 00	09000 CLI NI C	0	0		0	9	90. 00
91. 00	09100 EMERGENCY	0	1, 927, 844		0	9	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	148, 506		0	9	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0	9	94. 00
95.00	09500 AMBULANCE SERVICES					9	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	ol	0		0	•	96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD		0		o	l	97. 00
	09850 OTHER REIMBURSABLE COST CENTERS		0		o		98. 00
200.00	Total (lines 50-199)		14, 613, 785		0		00.00
200.00	10tul (111103 00 177)	١	17,013,703	I	σ _I	Į20	55. 50

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0183 Peri od: Worksheet D From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 5/27/2017 10:46 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 153048 3, 278, 950 501, 837 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.000000 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.007800 208, 016 1,623 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 405101 937, 471 0 0 379, 770 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 C 55 00 0 0 56.00 05600 RADI OI SOTOPE 0.000000 Ω 56.00 57.00 05700 CT SCAN 0.009716 2,044,896 19,868 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.059767 715, 552 0 58.00 42, 766 0 05900 CARDI AC CATHETERI ZATI ON 59 00 59 00 0.000000 0 60.00 06000 LABORATORY 0.124828 628, 016 78, 394 60.00 06001 BLOOD LABORATORY 0.000000 0 0 0 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0.000000 C 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 C 0 0 63.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 0 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 14, 185 65.00 0.169284 83. 792 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.292677 1,551 454 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.178807 593, 339 106, 093 69.00 οĺ 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.175217 2, 240, 649 0 0 392, 600 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.107630 675, 667 0 72, 722 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.278765 1, 129, 536 314, 875 73.00 366 0 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.000000 0 0 O 90.00 09100 EMERGENCY 1, 927, 844 0 439, 828 91.00 0. 228145 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.588626 148, 506 87, 414 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0. 000000 0 94.00 0 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 C 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 0 0 0 200.00 Subtotal (see instructions) 14, 613, 785 366 2, 452, 429 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 2, 452, 429 202. 00 202.00 Net Charges (line 200 +/- line 201) 14, 613, 785 366

Peri od: Worksheet D From 01/01/2016 Part V To 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am

					5/27/2017 10:	<u>46 am</u>
		Title	XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						4
50.00 05000 OPERATING ROOM	0	0				50. 00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	ol	O				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0				55. 00
	0	0				1
56. 00 05600 RADI 01 SOTOPE	0	0				56. 00
57.00 05700 CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	ol	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		ŭ,				61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	0					1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	ol	o				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0				72.00
	0	- 1				
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	102				73. 00
74. 00 07400 RENAL DI ALYSI S	0	0				74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	o	0				90.00
91. 00 09100 EMERGENCY	ol	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>				72.00
		0				1 04 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	U				94. 00
95. 00 09500 AMBULANCE SERVI CES	0					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00 Subtotal (see instructions)	l ol	102				200.00
201.00 Less PBP Clinic Lab. Services-Program		. 02				201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	102				202. 00
232. 33 ₁ Not onal 933 (1116 200 17 1116 201)	١	102	l			1-32. 00

Health Einancial Systems	MONROE HO	OSDI TAI		In Lie	u of Form CMS-	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		3 / col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SUBGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199) Cost Center Description	235, 313 117, 636 0 0 0 0 0 0 0 0 352, 949 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col.	117, 63	983 0	55. 84 119. 67 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00
INDATI ENT. DOUTINE CEDIM OF COOT CENTERS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 11.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199)	601 8 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems MONROE HOSPITAL In Lieu of Form					u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0183	Peri od:	Worksheet D	Worksheet D	
				From 01/01/2016	Part II		
				To 12/31/2016			
		Ti +I	e XIX	Hospi tal	5/27/2017 10: PPS	40 alli	
Cost Center Description	Capi tal	Total Charges			Capital Costs		
oost conten bescription	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x		
	(from Wkst. B,		(col . 1 ÷ col		column 4)		
	Part II, col.	8)	2)	3			
	26)	ĺ					
	1.00	2.00	3.00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	248, 979	21, 942, 087	0. 01134	7 952, 876	10, 812	50. 00	
51.00 05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52. 00	
53. 00 05300 ANESTHESI OLOGY	2, 572	1, 461, 076	0. 00176	0 68, 135	120	53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	163, 119	6, 171, 210	0. 02643	2 85, 998	2, 273	54.00	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0 0	0	55. 00	
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000	0 0	0	56. 00	
57. 00 05700 CT SCAN	9, 978	9, 080, 092	0. 00109	9 186, 153	205	57. 00	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	10, 243	2, 053, 114	0. 00498	9 27, 779	139	58. 00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59. 00	
60. 00 06000 LABORATORY	70, 936	15, 013, 569	0.00472	5 482, 534	2, 280	60.00	
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60. 01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000	0 0	0	62.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 0	0	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.00	
65. 00 06500 RESPIRATORY THERAPY	20, 259	3, 807, 201	0. 00532	1 391, 899	2, 085	65. 00	
66. 00 06600 PHYSI CAL THERAPY	4, 903	653, 348	0.00750	35, 922	270	66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67. 00	
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	4, 004	1, 602, 871	0. 00249	8 59, 886	150	69. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	114, 651	19, 775, 764	0. 00579	8 1, 029, 776	5, 971	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	34, 873	22, 173, 446	0. 00157	3 1, 266, 531	1, 992	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	34, 710	5, 962, 991	0. 00582	1 461, 155	2, 684	73. 00	
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000	0 0	0	74. 00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0	0	75. 00	
OUTPATIENT SERVICE COST CENTERS							
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000		0	88. 00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00	
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90. 00	
91. 00 09100 EMERGENCY	246, 733	15, 299, 231	0. 01612		3, 925		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 762	219, 224	0. 03540	0 0	0	92. 00	
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0. 00000	0 0	0	94.00	
95. 00 09500 AMBULANCE SERVI CES						95. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000		0	96. 00	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000		0	97. 00	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000		0	98. 00	
200.00 Total (lines 50-199)	973, 722	125, 215, 224		5, 292, 006	32, 906	200. 00	

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43.00

44.00

45.00

200. 00

33.00

34.00

200.00

03400 SURGICAL INTENSIVE CARE UNIT

Total (lines 30-199)

40. 00 | 04000 | SUBPROVI DER - I PF

41. 00 |04100 | SUBPROVI DER - I RF

45.00 04500 NURSING FACILITY

44.00 04400 SKILLED NURSING FACILITY

43. 00 | 04300 NURSERY

| In Lieu of Form CMS-2552-10 | Period: Worksheet D | From 01/01/2016 Part IV | To 12/31/2016 Date/Time Prepared: 5/27/2017 10: 46 am THROUGH COSTS

						5/27/2017 10: 4	46 am_
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician Nu	ırsing School	Allied Healt	n All Other	Total Cost	
	•	Anesthetist	3		Medi cal	(sum of col 1	
		Cost			Education Cost		
		0001			Ludouti oii ooot	4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51. 00	05100 RECOVERY ROOM		0		0 0	-	51.00
	05200 DELIVERY ROOM & LABOR ROOM		0			0	52.00
52. 00	I I	0	0		0	ŭ	
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 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	o	0		0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	Ö	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ü			J	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0			0	62.00
		0	0				
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00	06400 I NTRAVENOUS 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	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0		0 0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73. 00
	07400 RENAL DIALYSIS		0		0 0	0	74.00
	07500 ASC (NON-DISTINCT PART)		0		0 0	-	75. 00
75.00	OUTPATIENT SERVICE COST CENTERS	I U			0 0	U	75.00
00 00	08800 RURAL HEALTH CLINIC		0	I	0 0	0	00 00
88. 00		0	0			-	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90. 00	09000 CLI NI C	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 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0	94.00
95.00	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0		0 0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	ام	0		0 0	Ö	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		0		0 0	o	98. 00
200.00	I I		0		0 0	-	200. 00
200.00	1 10101 (111103 30 177)	١	U	I	- ₁ 0	١	200.00

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN	CILLARY SERVICE OTHER PASS Provider CCN: 15-0183	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2016 Part IV

11111000				Т	o 12/31/2016	Date/Time Pre 5/27/2017 10:	pared: 46 am
				e XIX	Hospi tal	PPS	40 diii
	Cost Center Description	Total		Ratio of Cost	Outpati ent	I npati ent	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS	_			,		
50.00	05000 OPERATING ROOM	0		0.000000		952, 876	
51. 00	05100 RECOVERY ROOM	0	0	0.000000		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	1, 461, 076			68, 135	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 171, 210			85, 998	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.000000		0	55. 00
56. 00	05600 RADI 0I SOTOPE	0	0	0.000000		0	56. 00
57. 00	05700 CT SCAN	0	9, 080, 092			186, 153	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 053, 114			27, 779	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000		0	
60.00	06000 LABORATORY	0	15, 013, 569			482, 534	
60. 01	06001 BLOOD LABORATORY	0	0	0.000000	0. 000000	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0. 000000	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0. 000000	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.000000	0. 000000	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	3, 807, 201	0.000000	0. 000000	391, 899	65. 00
66.00	06600 PHYSI CAL THERAPY	0	653, 348	0.000000	0. 000000	35, 922	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.000000	0. 000000	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0. 000000	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 602, 871	0.000000	0. 000000	59, 886	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0. 000000	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 775, 764	0.000000	0.000000	1, 029, 776	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	22, 173, 446	0.000000	0. 000000	1, 266, 531	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 962, 991	0.000000	0. 000000	461, 155	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0. 000000	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0. 000000	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89. 00
90.00	09000 CLI NI C	0	0	0.000000	0. 000000	0	90.00
91.00	09100 EMERGENCY	0	15, 299, 231	0.000000	0. 000000	243, 362	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	219, 224	0.000000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0. 000000	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0. 000000	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0. 000000	0	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0. 000000	0	98. 00
200.00	Total (lines 50-199)	0	125, 215, 224			5, 292, 006	200.00
		•	•				•

 Heal th Financial
 Systems
 MONROE
 HOSE

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 MONROE HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0183

Peri od: Worksheet D
From 01/01/2016 Part IV
To 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am THROUGH COSTS

						5/2//2017 10:	40 alli
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	'	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	1		
		Costs (col. 8	onal goo	Costs (col.			
		x col . 10)		x col . 12)	'		
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
50. 00	05000 OPERATING ROOM		C	V.	0		50.00
		0	-	1	-		
51.00	05100 RECOVERY ROOM	0	C	<u>'</u>	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	C)	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C)	0		55. 00
56.00	05600 RADI 0I SOTOPE	0	C)	0		56.00
57.00	05700 CT SCAN	0	C		0		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	ol .	0		59.00
60. 00	06000 LABORATORY	0	Ċ		o		60.00
60. 01	06001 BLOOD LABORATORY	0			0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1	٥		61. 00
	1 · ·		_				
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	<u>'</u>	0		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	<u>'</u>	0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	C)	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	C)	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C)	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C)	0		67. 00
68.00	06800 SPEECH PATHOLOGY	0	C)	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	C		0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	ol	C	ol .	0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o o			0		73. 00
74. 00	07400 RENAL DIALYSIS		C		0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)			1	0		75. 00
75.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	U _I		1 /5.00
00 00				<u>, </u>			- 00 00
88. 00	08800 RURAL HEALTH CLINIC	0	C	<u>'</u>	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C)	0		89. 00
90.00	09000 CLI NI C	0	C)	0		90. 00
91. 00	09100 EMERGENCY	0	C)	0		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C)	0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	C		0		94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	o	C		0		96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	ا	Ċ	ol	0		97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	ا	r		o		98. 00
200.00			C		0		200.00
200.00	/	ı V	C	7	9		1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0183 Peri od: Worksheet D From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 5/27/2017 10:46 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 153048 1, 478, 918 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52 00 0 52 00 0 0 87, 963 53.00 05300 ANESTHESI OLOGY 0.007800 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 405101 732, 758 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55 00 05600 RADI OI SOTOPE 56.00 0.000000 Ω 0 56.00 57.00 05700 CT SCAN 0.009716 1, 507, 212 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.059767 177, 970 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 59 00 C 0 60.00 06000 LABORATORY 0.124828 1, 118, 111 0 60.00 06001 BLOOD LABORATORY 0.000000 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS O 62 00 0.000000 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 63.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0. 169284 213, 495 0 65.00 06600 PHYSI CAL THERAPY 0.292677 66.00 344 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 C 0 67.00 06800 SPEECH PATHOLOGY 68.00 0.000000 C 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0.178807 136, 392 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.175217 1, 663, 029 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.107630 551, 603 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.278765 1,080,848 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 Ω C 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.000000 0 0 90.00 09100 EMERGENCY 4, 398, 275 91.00 0. 228145 0 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.588626 57,635 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0. 000000 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 C 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 98.00 0 0 200.00 Subtotal (see instructions) C 13, 204, 553 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

0 202.00

13, 204, 553

202.00

Net Charges (line 200 +/- line 201)

Peri od: Worksheet D From 01/01/2016 Part V To 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am Provi der CCN: 15-0183

						5/27/2017 10: 4	l6 am
			Ti tl	e XIX	Hospi tal	PPS	
	·	Cos			•		
	Cost Center Description	Cost	Cost				
	300 t 3011tor 3000 r p t 1 0 11	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		_					
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	226, 345	0				50.00
51. 00	05100 RECOVERY ROOM	0	0				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00	05300 ANESTHESI OLOGY	686	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	296, 841	0				54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
	05600 RADI OI SOTOPE	0	l ő				56. 00
		· · · · · ·	0				
	05700 CT SCAN	14, 644					57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 637	0				58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
	06000 LABORATORY	139, 572	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	06400 I NTRAVENOUS THERAPY	0	0				64. 00
	06500 RESPIRATORY THERAPY	36, 141	Ö				65. 00
	06600 PHYSI CAL THERAPY	101	0				66. 00
		0	0				
	06700 OCCUPATI ONAL THERAPY	0	l e				67.00
	06800 SPEECH PATHOLOGY	0	0				68. 00
	06900 ELECTROCARDI OLOGY	24, 388	l e				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	291, 391	0				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	59, 369	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	301, 303	0				73.00
74. 00	07400 RENAL DIALYSIS	0	0				74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0				75.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1				89. 00
	09000 CLINIC		0				90.00
		1 000 111					
	09100 EMERGENCY	1, 003, 444	l .				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 925	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0				94.00
95. 00	09500 AMBULANCE SERVICES	0					95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			İ	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.00
	09850 OTHER REIMBURSABLE COST CENTERS	l n	0				98. 00
200.00	Subtotal (see instructions)	2, 438, 787	0			,	200.00
200.00		2,430,707					200. 00
201.00	Less PBP Clinic Lab. Services-Program					-	201.00
202.00	Only Charges (Line 200 // Line 201)	2 420 707	_			,	202 00
202. 00	Net Charges (line 200 +/- line 201)	2, 438, 787	0	l		-	202. 00

Health Financial Systems MONROE HOSPITAL In Lieu of Form CMS						
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0183	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/27/2017 10:			
	Title XVIII	Hospi tal	PPS			
Cost Center Description						
			1. 00			
PART I - ALL PROVIDER COMPONENTS						

PART - ALL PROVIDER COMPONENTS			Title XVIII	Hospi tal	PPS		
NAMELH LIMPS		Cost Center Description			1 00		
NAMTLERIT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00		
1.00 Impatient days (Including private room days, excluding swing-hed and newborn days) 4.214 2.00							
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00						•	
do not complete this line.							
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10 10 10 10 10 10 10 10	5.00		om days) through December	31 of the cost	0	5. 00	
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5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 X line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Decenral inpatient routine service charges (excluding swing-bed charges) Decenral inpatient routine service cost net of swing-bed and observation bed charges) Decenral inpatient routine service cost net of swing-bed and observation bed charges) Decenral inpatient routine service cost/charge ratio (line 27 + line 28) Decenral inpatient routine service cost/charge ratio (line 27 + line 28) Decenral inpatient routine service cost/charge ratio (line 27 + line 28) Decenral inpatient routine service cost/charge ratio (line 27 + line 28) Decenral inpatient routine service cost/charge ratio (line 30 + line 31) Decenral inpatient routine service cost (line 30 + line 31) Decenral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 31) Decenral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) Decenral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) Decenral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) Decenral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) Decenral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) Decenral inpatien				ng period (line		1	
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24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average perivate room per diem charge (line 29 ÷ line 3) 31.00 Average perivate room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) 37.00 Average per diem private room cost differential (line 3 x line 31) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		31 of the cost reporting	period (line 6	0	23. 00	
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24 00	,	- 31 of the cost reportin	ng period (line	0	24.00	
x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 PRI vate room charges (excluding swing-bed and observation bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912,074) PRI VATE ROOM DIFFERENTIAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Average per al inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost per diem (see instructions) Porgram general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line	24.00		31 of the cost reportin	ig perrod (Trile	O	24.00	
26. 00 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 29. 00 29. 00 29. 00 30. 00	25. 00		31 of the cost reporting	period (line 8	0	25. 00	
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30. 00 Average private room per diem charge (line 29 ÷ line 3) 30. 00 Average private room per diem charge (line 30 ÷ line 4) 30. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 34 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Avera	24 00				0	24 00	
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 9.00 Semi-pri vate room charges (excluding swing-bed charges) 9.00 Semi-pri vate room charges (excluding swing-bed charges) 9.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 9.00 Average pri vate room per diem charge (line 29 + line 3) 9.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 9.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 9.00 Average per diem pri vate room cost differential (line 34 x line 31) 9.00 Average per diem pri vate room cost differential (line 3 x line 35) 9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) 9.00 Adj usted general inpatient routine service cost per diem (see instructions) 9.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 88.00 Adj usted general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost per diem (see instructions) 9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, ,	(line 21 minus line 26)				
29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room per diem charge (line 27 ÷ line 28) 30. 00 Average private room per diem charge (line 29 ÷ line 3) 31. 00 Average per diem private room per diem charge (line 30 ÷ line 4) 32. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32. 00 Average per diem private room cost differential (line 34 x line 31) 33. 00 Average per diem private room cost differential (line 3 x line 35) 34. 00 Private room cost differential adjustment (line 3 x line 35) 35. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) 37. 00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00	27.00		(11116 21 111110 11116 20)		0, 7.12, 07.1	27.00	
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 decental inpatient routine service cost applicable to the Program (line 14 x line 35) 40.00 decental inpatient routine service cost applicable to the Program (line 14 x line 35) 40.00 decental inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 9.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 32.00 0.00 33.00 0.00 34.00 35.00 Average per diem private room cost differential (line 3, 912, 074) 0.00 35.00 0.00 36.0							
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.			line 28)				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 928.35 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 33.00 0 .00 34.00 37.00 35.00 38.00 36.00 39.00 Program general inpatient routine service cost per diem (see instructions) 928.35 38.00 40.00		,	11116 20)			1	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 928.35 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,				1	
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 912, 074 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 928.35 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				i ons)		1	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 928.35 38.00 929.35 39.00 920.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 940.00		9	ne 31)			1	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 928.35 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	and private room cost dif	ferential (line	-	1	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 928.35 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,146,345 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)	,				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 928.35 38.00 929.35 38.00 920.00 Program general inpatient routine service cost (line 9 x line 38) 920.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 920.00 0 40.00			IOTHENTO.				
39.00 Program general inpatient routine service cost (line 9 x line 38) 2,146,345 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	20 00				020 25	20 00	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			1	
					0	40. 00	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,146,345 41.00	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 146, 345	41. 00	

Heal th	Financial Systems	MONROE HOSE	PI TAL_		In Lie	u of Form CMS-2	<u>2552</u> -10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0183	Period: From 01/01/2016	Worksheet D-1	
					To 12/31/2016	Date/Time Pre	
			Title	xVIII	Hospi tal	5/27/2017 10: 2 PPS	46 am_
	Cost Center Description	Total	Total	Average Per		Program Cost	
	· In	patient Cost <mark>l</mark> n	npatient Days		÷	(col. 3 x col.	
	_	1.00	2.00	col . 2) 3.00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00				42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00	INTENSIVE CARE UNIT	1, 854, 663	983			262, 257	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	O O	0			0	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	Ö	0			0	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst.	D-3. col. 3.	line 200)			3, 765, 132	48. 00
	Total Program inpatient costs (sum of lines 41			ns)		6, 173, 734	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpati	ent routine se	ervices (from	ı Wkst. D, sun	n of Parts I and	145, 736	50. 00
51. 00	Pass through costs applicable to Program inpati	ent ancillary	services (fr	om Wkst. D, s	sum of Parts II	137, 793	51. 00
	and IV)						
52. 00 53. 00	Total Program excludable cost (sum of lines 50 Total Program inpatient operating cost excluding		atod non nhv	eician anoeth	notist and	283, 529 5, 890, 205	52. 00 53. 00
55.00	medical education costs (line 49 minus line 52)	9 1	itea, non-pny	Si Ci ali allesti	ietist, and	5, 690, 205	55.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program di scharges					0	54. 00
56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	, ,	cost and targ	get amount (I	ine 56 minus	line 53)	Ö	57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repormarket basket	ting period er	nding 1996, u	ipdated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cos	st report, upda	ated by the m	arket basket		0. 00	60. 00
61. 00	If line 53/54 is less than the lower of lines 5					0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see ins		(lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	er de trons)				0	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							64. 00
04.00	instructions) (title XVIII only)	trii ougir beceiik	bei 31 of the	cost reporti	ng perrou (see	U	04.00
65. 00	Medicare swing-bed SNF inpatient routine costs	after December	31 of the c	ost reportino	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine	costs (line 6/	1 nlue lina 6	5)(+i+l_ YVII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	COSTS (TITLE OF	F prus rine o	o)(title xvii	1 Om y). 101	J	00.00
67. 00	9 1	costs through D	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine of	nsts after Dec	rember 31 of	the cost rend	orting period	0	68. 00
00.00	(line 13 x line 20)	osts arter bec	Sember 01 01	the cost rept	n tring period		00.00
69. 00	3					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURS Skilled nursing facility/other nursing facility						70. 00
71. 00	Adjusted general inpatient routine service cost						71. 00
72. 00	Program routine service cost (line 9 x line 71)			25)			72.00
73. 00 74. 00	Medically necessary private room cost applicabl Total Program general inpatient routine service						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient rou	•	,		Part II, column		75. 00
	26, line 45)		•		·		
76. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line 76	•					76. 00
77. 00 78. 00	Inpatient routine service cost (line 74 minus l						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess of	costs (from pro		· .			79. 00
80.00	Total Program routine service costs for compari		st limitation	(line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitat Inpatient routine service cost limitation (line						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see	· .)				83. 00
84. 00	Program inpatient ancillary services (see instr	,					84. 00
85. 00 86. 00	Utilization review - physician compensation (se Total Program inpatient operating costs (sum of						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS T		Jagii 00)				55. 55
87. 00	Total observation bed days (see instructions)					139	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per die Observation bed cost (line 87 x line 88) (see i	•	ine 2)			928. 35 129, 041	
57.00	Toboti varion bed cost (Time of A Time ob) (See I	noti deti ono)			J	127, 041	37.00

Health Financial Systems MONROE HOSPI				PITAL In Lieu of Form CMS-25			2552-10
COMPUTATION OF INPATIENT OPERA		Provi der CO	Provider CCN: 15-0183		Worksheet D-1		
					From 01/01/2016 To 12/31/2016	Date/Time Prep 5/27/2017 10:4	pared: 46 am
			Title	XVIII	Hospi tal	PPS	
Cost Center Descr	i pti on	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVAT	ION BED PASS THROUGH (COST					
90.00 Capital -related cost		235, 313	3, 912, 074	0. 060150	129, 041	7, 762	90.00
91.00 Nursing School cost		O	3, 912, 074	0. 000000	129, 041	0	91.00
92.00 Allied health cost		o	3, 912, 074	0. 000000	129, 041	0	92.00
93.00 All other Medical Educa	nti on	o	3, 912, 074	0. 00000	129, 041	0	93.00

Heal th	Financial Systems MONROE HOSPITAL	_	In Lie	u of Form CMS-2	2552-10
	<i>y</i>	ovi der CCN: 15-0183	Peri od:	Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 5/27/2017 10:	
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
	DADT I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days, e	veluding newborn)		4, 214	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed			4, 214	
3.00	Private room days (excluding swing-bed and observation bed days).		ivate room days	4, 214	
3.00	do not complete this line.	ii you have only pr	i vate i oom days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed d	avs)		4, 075	4.00
5.00	Total swing-bed SNF type inpatient days (including private room d		r 31 of the cost	0	1
	reporting period	3,			
6.00	Total swing-bed SNF type inpatient days (including private room d	ays) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room da	ys) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room da	ys) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to th	e Program (excluding	swing-bed and	601	9. 00
10 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	(including private n	oom days)	0	10.00
10. 00	through December 31 of the cost reporting period (see instruction		oom days)	Ü	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter		dom days) arter	O	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX on		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 (
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX on	ly (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year,	enter 0 on this lin	e)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed	days)	0	14.00
15. 00				0	
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services t	hrough December 31 o	f the cost	0. 00	17. 00
10.00	reporting period	CI D I 01 C		0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services a	Tier December 31 of	tne cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services th	rough Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	rough becember 31 01	the COST	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services af	ter December 31 of t	he cost	0.00	20.00
_0.00	reporting period			3.00	=0.00
21. 00				3, 912, 074	21.00
22.00	Swing-bed cost applicable to SNF type services through December 3	1 of the cost report	ing period (line		

	Cost Center Description	1.00	
	DADT I ALL DROWLDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 214	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 214	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4, 075	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		,
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	_	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	601	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instructions)		44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Ü	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17.00	SWING BED ADJUSTMENT	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period	0.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21 00	reporting period	2 012 074	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line)	3, 912, 074 0	21. 00 22. 00
22.00	5 x line 17)	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
05.00	7 x line 19)	0	05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 912, 074	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	<i>5</i> / · · · = / <i>5</i> · · ·	
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	3, 912, 074	
57.00	27 minus line 36)	5, 7,12, 5,74	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	928. 35	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	557, 938	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00

<u>Hea</u> l th	Financial Systems	MONROE HOS	PI TAL		In Lie	u of Form CMS-2	<u> 2552-</u> 10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0183	Peri od: From 01/01/2016	Worksheet D-1	
					To 12/31/2016		
			Ti +I	e XIX	Hospi tal	5/27/2017 10: PPS	46 am_
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost Ir	npatient Days		÷	(col. 3 x col.	
		1. 00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	C				42. 00
42.00	Intensive Care Type Inpatient Hospital Units	1, 854, 663	983	1, 886.	74 8	15 004	43. 00
43. 00 44. 00	CORONARY CARE UNIT	1, 854, 663	983			15, 094 0	44. 00
45. 00		o	0	1		Ö	
46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0. (00 0	0	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wks			,,,,,		833, 299	
49.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	i through 48)(Se	ee instructio	ons)		1, 406, 331	49.00
50.00	Pass through costs applicable to Program inpa	tient routine se	ervices (from	n Wkst. D, sur	m of Parts I and	34, 517	50. 00
51. 00		tiont ancillary	corvi cos (fr	som Wkst D	sum of Dorte II	32, 906	51. 00
51.00	and IV)	ittent ancitrary	services (II	OIII WKSt. D, :	Sum Of Farts II	32, 400	31.00
52.00	Total Program excludable cost (sum of lines 5	,				67, 423	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		ated, non-phy	sician anestl	netist, and	1, 338, 908	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	(2)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ng cost and targ	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period er	nding 1996, u	ipdated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year o					0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		(Tines 54 X	60), or 1% or	r the target		
62. 00	Relief payment (see instructions)	•				0	
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	tions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cost	s through Decemb	per 31 of the	cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)	CI D I	04 6 11				/F 00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s arter December	and the c	cost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routin	e costs (line 64	1 plus line 6	55)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through [Occombor 21 c	of the cost re	operting period	0	67. 00
67.00	(line 12 x line 19)	costs through t	becember 31 c	or the cost re	eporting perrou	0	07.00
68. 00	Title V or XIX swing-bed NF inpatient routine	costs after Dec	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	coutine costs (li	ne 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	· · · · · · · · · · · · · · · · · · ·					
70. 00 71. 00	Skilled nursing facility/other nursing facili	,)		70. 00 71. 00
71.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ie 70 ÷ i i ne	2)			71.00
73. 00	Medically necessary private room cost applica	ble to Program (73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				Part II column		74. 00 75. 00
75.00	26, line 45)	outine service (LOSTS (TIOIII II	ioi ksileet b, i	-art II, Corumn		75.00
76. 00	Per diem capital-related costs (line 75 ÷ lin						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		ovi der record	ls)			79. 00
80.00	Total Program routine service costs for compa		st limitation	ı (line 78 miı	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (s	· · · · · · · · · · · · · · · · · · ·)				83. 00
84.00	Program inpatient ancillary services (see ins		-)				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	THROUGH COST					
87.00	Total observation bed days (see instructions)		ino 2)			139	
88. 00 89. 00	Adjusted general inpatient routine cost per d Observation bed cost (line 87 x line 88) (see		1116 Z)			928. 35 129, 041	
		,					•

Health Financial Systems			SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING C	OST		Provi der CC		Peri od:	Worksheet D-1	
					From 01/01/2016		
					To 12/31/2016	Date/Time Prep 5/27/2017 10:4	
			T: ±1	- VIV	11		40 alli
				e XIX	Hospi tal	PPS	
Cost Center Description		Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED	PASS THROUGH (COST					
90.00 Capital -related cost		235, 313	3, 912, 074	0. 06015	0 129, 041	7, 762	90. 00
91.00 Nursing School cost		o	3, 912, 074	0.00000	0 129, 041	0	91. 00
92.00 Allied health cost		o	3, 912, 074	0.00000	0 129, 041	0	92.00
93.00 All other Medical Education		o	3, 912, 074	0.00000	0 129, 041	0	93. 00

				To 12/31/2016	Date/Time Pre 5/27/2017 10:	
		Ti tl e	e XVIII	Hospi tal	PPS	TO GIII
	Cost Center Description		Ratio of Cos		Inpatient	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS			2, 756, 279		30. 00
	03100 INTENSIVE CARE UNIT			371, 817		31. 00
	03200 CORONARY CARE UNIT			0		32. 00
	03300 BURN INTENSIVE CARE UNIT			0		33. 00
	03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER - I RF			0		41. 00
	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS		0.1530	0 4 155 174	/25 041	F0 00
	05000 OPERATI NG ROOM		0. 15304		l .	50.00
	05100 RECOVERY ROOM		0.00000		0	51.00
	05200 DELIVERY ROOM & LABOR ROOM		0.00000			
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C		0.00780	· ·		
			0.40510	· ·		54. 00 55. 00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		0.00000		0	
	05700 CT SCAN		0.00000			57.00
	05700 MAGNETIC RESONANCE IMAGING (MRI)		0. 00971 0. 05976			1
	05800 MAGNETT C RESONANCE TWAGTING (WRT) 05900 CARDI AC CATHETERI ZATI ON		0.00000		0, 449	1
	06000 LABORATORY		0. 12482			
	06001 BLOOD LABORATORY		0. 00000		203, 788	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	
	06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
	06400 I NTRAVENOUS THERAPY		0. 00000		ő	1
	06500 RESPIRATORY THERAPY		0. 16928			65.00
	06600 PHYSI CAL THERAPY		0. 29267			
	06700 OCCUPATI ONAL THERAPY		0.00000		0	67. 00
	06800 SPEECH PATHOLOGY		0.00000		Ō	
	06900 ELECTROCARDI OLOGY		0. 17880			
70. 00	07000 ELECTROENCEPHALOGRAPHY		0.00000	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 17521	7 3, 928, 163	688, 281	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 10763	9, 346, 230	1, 005, 935	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 27876	5 1, 640, 909	457, 428	73. 00
74.00	07400 RENAL DIALYSIS		0.00000	0 0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0.00000	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
	09000 CLI NI C		0.00000		0	90.00
	09100 EMERGENCY		0. 22814			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 58862	6 3, 790	2, 231	92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09400 HOME PROGRAM DIALYSIS		0.00000	0	0	
	09500 AMBULANCE SERVICES					95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	
	09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	97. 00
	09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	
200.00	Total (sum of lines 50-94 and 96-98)	(1)		25, 261, 010	3, 765, 132	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(IINE 61)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		201. 00
202. 00	Net Charges (line 200 minus line 201)		I	25, 261, 010	1	202. 00

Health Financial Systems	MONROE HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0183 F	Peri od:	Worksheet D-3	
		F	rom 01/01/2016		
		Τ	o 12/31/2016	Date/Time Prepared: 5/27/2017 10:46 am	
	Ti t	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	Inpati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 O3000 ADULTS & PEDIATRICS			652, 723		30.00
					1
31. 00 03100 INTENSIVE CARE UNIT			19, 898		31.00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGI CAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS			"		1
50. 00 05000 OPERATING ROOM		0. 153048	952, 876	145, 836	50.00
51. 00 05100 RECOVERY ROOM		0.000000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM				0	52.00
		0.000000		_	1
53. 00 05300 ANESTHESI OLOGY		0.007800		531	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 405101		34, 838	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.000000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE		0.000000	0	0	56. 00
57. 00 05700 CT SCAN		0.009716	186, 153	1, 809	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.059767	27, 779	1, 660	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.000000		0	59.00
60. 00 06000 LABORATORY		0. 124828		60, 234	1
60. 01 06001 BLOOD LABORATORY		0. 000000		00, 234	60. 01
				_	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.000000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.000000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0.000000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 169284	391, 899	66, 342	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 292677	35, 922	10, 514	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.000000	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.000000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 178807	59, 886	10, 708	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.000000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 175217		180, 434	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 107630		136, 317	1
		1			ı
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 278765		128, 554	
74. 00 07400 RENAL DI ALYSI S		0.000000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0.000000	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.000000	0	0	88. 00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.000000	0	0	89. 00
90. 00 09000 CLI NI C		0.000000	0	0	90.00
91. 00 09100 EMERGENCY		0. 228145	243, 362	55, 522	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 588626			92.00
OTHER REIMBURSABLE COST CENTERS		0.0002	,	J	72.00
94. 00 O9400 HOME PROGRAM DI ALYSI S		0.000000	0	0	94. 00
		0.000000	,	U	
					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.000000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.000000		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.000000	0	0	98. 00
200.00 Total (sum of lines 50-94 and 96-98)			5, 292, 006	833, 299	200.00
201.00 Less PBP Clinic Laboratory Services-Program of	only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			5, 292, 006		202. 00
1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1		ı	

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0183	Peri od: Worksheet E From 01/01/2016 Part A To 12/31/2016 Date/Ti me Prepared: 5/27/2017 10:46 am

		Title XVIII	Hospi tal	5/27/2017 10: 4	46 am
		II tie XVIII	nospi tai	113	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (s	see	0 4, 115, 280	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	(see	1, 302, 014	1. 02	
1.03	DRG for federal specific operating payment for Model 4 BPCI for (1 (see instructions)	0	1. 03		
1. 04	DRG for federal specific operating payment for Model 4 BPCI for (October 1 (see instructions)	discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			2, 030, 923 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions	s)		0	2. 02
3.00	Managed Care Simulated Payments			0	3. 00
4. 00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	ng period (see instru	ctions)	31. 53	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most reor before 12/31/1996. (see instructions)	ecent cost reporting p	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-o	on to the cap	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under			0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified und If the cost report straddles July 1, 2011 then see instructions.	der 42 CFR §412.105(f)	(1)(IV)(B)(2)	0.00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If				8. 01
8. 02	the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (instructions)	(8, 8,01 and 8,02) (s	see	0.00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podiatric programs.	year from your record	ds	0.00	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)				
13.00	Total allowable FTE count for the prior year.			0.00	13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	ember 30, 1997,	0.00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				
17. 00	Adjustment for residents displaced by program or hospital closure	е			17. 00
18. 00	Adjusted rolling average FTE count			0.00	
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000 0. 000000	
21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22.00
22. 01	IME payment adjustment - Managed Care (see instructions)			ő	22. 01
22.0.	Indirect Medical Education Adjustment for the Add-on for Section	422 of the MMA		- J	
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.	cap slots under 42 Se	ec. 412.105	0.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower instructions)	er of line 23 or line	24 (see	0. 00	
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruct	i ons)	2. 03	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	J (11 11 11 11 11 11 11 11 11 11 11 11 1	´	23. 19	
32.00	Sum of lines 30 and 31			25. 22	32. 00
	Allowable disproportionate share percentage (see instructions)			9. 14	
34. 00	Disproportionate share adjustment (see instructions)			123, 785	34.00

	· · · · · · · · · · · · · · · · · · ·	HOSPI TAL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0183	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre	nared:
			10 12/31/2010	5/27/2017 10:	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)		6, 406, 145, 534	5, 977, 483, 147 0. 000000001	
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line)	0. 000000001	0. 000000001	1
00.02	(see instructions)	56. 20.0 0 16 116,		S	00.02
35. 03			4	2	
30.00	Total uncompensated care (sum of columns 1 and 2 on line Additional payment for high percentage of ESRD beneficiar		1ah 46)		36. 00
40. 00	Total Medicare discharges on Worksheet S-3, Part I exclud		0		40. 00
41 00	652, 682, 683, 684 and 685 (see instructions)	22 /02 /04 on /05 /000	0		41 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 68 instructions)	32, 683, 684 an 685. (See	0		41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding	y MS-DRGs 652, 682, 683, 68	4 0		41. 01
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not o	auglify for adjustment)	0.00		42. 00
42.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652				43.00
	instructions)	•			
44. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instruct	i ons)	0.00		45.00
46. 00	Total additional payment (line 45 times line 44 times lin		0		46. 00
47. 00	, ,	NII amali rural baani tala	7, 572, 008		47.00
48. 00	Hospital specific payments (to be completed by SCH and MD only. (see instructions)	on, siliari rurai nospitars	0		48. 00
	, (222			Amount	
40.00	Total nament for impatient approxima costs (cost instruct	ei ana)		1. 00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instruct Payment for inpatient program capital (from Wkst. L, Pt.)	7, 572, 008 755, 749	1
51. 00	Exception payment for inpatient program capital (Wkst. L,	Pt. III, see instructions)	,	0	
52.00	Direct graduate medical education payment (from Wkst. E-4	4, line 49 see instructions)		0	
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0	
54. 01	Islet isolation add-on payment			0	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	· ·		0	
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see Routine service other pass through costs (from Wkst. D, F		through 35)	0	
58. 00	Ancillary service other pass through costs from Wkst. D,		em ough ooy.	0	
59. 00	, ,			8, 327, 757	
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 m	ninus line 60)		0 8, 327, 757	
62. 00	Deductibles billed to program beneficiaries	inds time 60)		636, 020	
63. 00	Coinsurance billed to program beneficiaries			5, 796	
64.00	1			0	1
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		7, 685, 941	•
68. 00	Credits received from manufacturers for replaced devices			0	1
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	96). (For SCH See Instruction	ns)	0	1
70. 50	RURAL DEMONSTRATION PROJECT			0	
70. 88	SCH or MDH volume decrease adjustment			0	
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see HSP bonus payment HVBP adjustment amount (see instruction			0	
, 0. 70	HSP bonus payment HRR adjustment amount (see instructions			0	
70. 91	,	•		0	
70. 92	Bundled Model 1 discount amount (see instructions)				
				0	70. 93

Heal th	Financial Systems MONROE HOSE	PI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0183	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A	pared:
		Title	: XVIII	Hospi tal	PPS	
			FFY	['] (уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97				0	0	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	1				0	
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			7, 685, 941	ł
71. 01	Sequestration adjustment (see instructions)				153, 719	
	Interim payments				7, 456, 566	
	Tentative settlement (for contractor use only)				0	
74. 00					75, 656	1
75. 00	Protested amounts (nonallowable cost report items) in accorda	nce with			189, 311	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1		_	
90.00	-p	tructions)			0	
91.00					0	
92.00	Operating outlier reconciliation adjustment amount (see instr				0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
	The rate used to calculate the time value of money (see instr				0.00	
	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instruc	TI ONS)		D: +- 10/1	0 (15)	96. 00
				Prior to 10/1 1.00	2. 00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)			0	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			0	U	100.00
101 00	HVBP adjustment factor (see instructions)			0. 000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instruction	c)		0.000000000		101.00
102.00	HRR Adjustment for HSP Bonus Payment (see Instruction	3)		0	U	102.00
102 00	HRR adjustment factor (see instructions)			0.0000	0.0000	102 00
	HRR adjustment amount for HSP bonus payment (see instructions)		0.0000		103.00
104.00	Think and astiment amount for his bonus payment (see Instructions	,		ı	0	1104.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2016 | Part A Exhibit 4 | To 12/31/2016 | Date/Time Prepared: 5/27/2017 10: 46 am Provider CCN: 15-0183

line E, Part A) Enti	Title re/Post itlement 2.00 0 0 0	Peri od Pri or to 10/01 3.00 0 4,115,280	Hospi tal Peri od On/After 10/01 4.00 1,302,014	Total (Col 2 through 4) 5.00 0 4,115,280 1,302,014	1. 01
line E, Part A) Enti	itlement 2.00 0 0 0	to 10/01 3.00 0 4,115,280	0n/After 10/01 4.00 0	through 4) 5.00 0 4,115,280 1,302,014	1. 01
1.00 DRG amounts other than outlier payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for cotober 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI Occurring on or after October 1 2.00 Outlier payments for discharges for Model 4 BPCI Occurring on or after October 1 2.00 Outlier payments for discharges for Model 4 BPCI Operating outlier payments for discharges for Model 4 BPCI Operating outlier oreconciliation	0 0 0	4, 115, 280 C	0	0 4, 115, 280 1, 302, 014 0	1. 01
payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 2.00 Outlier payments for cotober 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCl Operating outlier payments for cotober 1 2.00 Operating outlier 2.01 Operating outlie	0 0	4, 115, 280 0		4, 115, 280 1, 302, 014 0	1. 01
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 2.00 Outlier payments for outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCl Operating outlier operating outlier operating outlier o	0	C		1, 302, 014	1. 02
occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI occurring on October 1 2.00 Operating outlier outlier outlier outlier payments for outlier outlie	0 0		1, 302, 014	0	1. 03
payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for of discharges (see instructions) 2.01 Outlier payments for of discharges for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for of discharges for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for of outlier payments for of discharges for Model 4 BPCI occurring outlier of outlier of conciliation	0 0	0	1, 302, 014	0	1. 03
occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for of ischarges (see instructions) Outlier payments for of ischarges for Model 4 BPCI Occurring on or after October 1 2.00 Outlier payments for of ischarges for Model 4 BPCI Occurring on or after October 1 2.00 Outlier payments for of ischarges for Model 4 Derating outlier of conciliation or operating outlier or reconciliation	0	C	0		
1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 2.00 2,030,923 discharges (see instructions) 2.01 Outlier payments for 2.02 0 discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 perating outlier 2.01 0 reconciliation	0	C	0		
operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific Operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI 3.00 Operating outlier reconciliation	0	C	О		
BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 2.00 2,030,923 discharges (see instructions) 2.01 Outlier payments for 2.02 0 discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 preconciliation	0	700.10	0	0	1. 04
October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for 2.00 2,030,923 discharges for Model 4 BPCI operating outlier 2.01 0 operating outlier 2.01 0 oreconciliation	0		0	0	1. 04
1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI 3.00 Operating outlier 2.01 Operating outlier	0	700 404	0	0	1. 04
BPCI occurring on or after October 1 2.00 Outlier payments for 2.00 2,030,923 discharges (see instructions) 2.01 Outlier payments for 2.02 0 discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 reconciliation	0	700 404			
October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCl 3.00 Operating outlier 2.01 Operating	0	700 404			
2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCl 3.00 Operating outlier 2.01 Operating outlier 2.00	0	700 404			
2.01 Outlier payments for 2.02 O discharges for Model 4 BPCl 3.00 Operating outlier 2.01 O reconciliation	0	799, 406	1, 231, 517	2, 030, 923	2.00
discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 reconciliation	UI	0	0	0	2.01
3.00 Operating outlier 2.01 Oreconciliation	1	U	0	0	2. 01
	0	C	0	0	3.00
4.00 Managed care Simulated 3.00 Ol					4 00
payments	U	U	0	0	4.00
Indirect Medical Education Adjustment					
5.00 Amount from Worksheet E, Part 21.00 0.000000	0. 000000	0. 000000	0. 000000		5. 00
A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 0	0	0	0	0	6.00
instructions)	Ĭ	C			0.00
6.01 IME payment adjustment for 22.01 0	0	C	0	0	6. 01
managed care (see instructions)					
Indirect Medical Education Adjustment for the Add-on for Section	1 422 of th	ne MMA			
7.00 IME payment adjustment factor 27.00 0.000000	0. 000000	0. 000000	0. 000000		7. 00
(see instructions) 8.00 IME adjustment (see 28.00 0	0	C	0	0	8.00
instructions)				_	
8.01 IME payment adjustment add on 28.01 0	0	C	0	0	8. 01
for managed care (see instructions)					
9.00 Total IME payment (sum of 29.00 0	0	C	0	0	9. 00
lines 6 and 8) 9.01 Total IME payment for managed 29.01 0	0	0	0	0	9. 01
care (sum of lines 6.01 and	U	C	0	0	9.01
8. 01)					
Di sproporti onate Share Adjustment 10.00 Allowable di sproporti onate 33.00 0.0914	0. 0914	0. 0914	0. 0914		10.00
share percentage (see	0.0714	0.0714	0.0714		10.00
instructions)	_				
11.00 Disproportionate share 34.00 123,785 adjustment (see instructions)	0	94, 034	29, 751	123, 785	11.00
11. 01 Uncompensated care payments 36.00 6	0	4	2	6	11. 01
Additional payment for high percentage of ESRD beneficiary discharge		_	_	_	4
12.00 Total ESRD additional payment 46.00 0 (see instructions)	0	C	0	0	12.00
13. 00 Subtotal (see instructions) 47.00 7,572,008	0	5, 008, 724	2, 563, 284	7, 572, 008	13.00
14.00 Hospital specific payments 48.00 0	0	C	0	0	14. 00
(completed by SCH and MDH, small rural hospitals only.)					
(see instructions)					
15.00 Total payment for inpatient 49.00 7,572,008	0	5, 008, 724	2, 563, 284	7, 572, 008	15. 00
operating costs (see instructions)					
16.00 Payment for inpatient program 50.00 755,749	0	419, 719	336, 030	755, 749	16. 00
capi tal					
17.00 Special add-on payments for 54.00 0 new technologies	0	C	0	0	17. 00
17.01 Net organ aquisition cost					17. 01
17.02 Credits received from 68.00 0	0	C	0	0	
manufacturers for replaced devices for applicable MS-DRGs					
18.00 Capital outlier reconciliation 93.00 0	o	C	0	0	18. 00
adjustment amount (see	1				
instructions)			1		1

						rom 01/01/2016		
					1	o 12/31/2016	Date/Time Pre 5/27/2017 10:	
				Ti tl o	XVIII	Hospi tal	PPS	40 alli
		W/S F Dart A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01		
		0	1.00	2.00	3.00	4. 00	5. 00	
19 00	SUBTOTAL		1.00	0.00				19 00
17.00	308101712	W/S L, line	(Amounts from	Ü	0, 120, 110	2,077,011	0,021,101	17.00
		, 0 2,0	L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1, 00	432, 630	0	328, 120			20.00
20. 01	Model 4 BPCI Capital DRG other		0	0	0	0	0	20. 01
	than outlier		_		_		_	
21.00	Capital DRG outlier payments	2. 00	323, 119	0	91, 599	231, 520	323, 119	21.00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	. 0	0	0	21. 01
	outlier payments							
22.00		5. 00	0.0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0	0	0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0. 0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11. 00	0	0	0	0	0	25. 00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	755, 749	0	419, 719	336, 030	755, 749	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)					
	I	0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 000000	0. 000000		27. 00
28. 00		70. 96			0)	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
100.00	Pt. A, line)							100.00
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.	1				ļ		I

 Heal th Financial
 Systems
 MONROE
 HODE

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT
 5
 Provider CCN: 15-0183

Misst. E, Pt. A. Line Misst. E, Pt.					11	0 12/31/2016	5/27/2017 10: 4	
West E. Pt. All Tine West E. Pt. All Tine West E. Pt. 10/01 affter				Title	XVIII	Hospi tal		10 4
1.00 DRG amounts other than outlier payments 1.00 1.00 2.00 3.00 4.00 1.00			Wkst. F. Pt.					
0			· ·					
1.00 DRC amounts other than outlier payments 1.00 4.115, 280 4.115, 280 1.01 1.01 DRC amounts other than outlier payments for 1.01 4.115, 280 4.115, 280 1.01 1.02			·	A)			ŕ	
1.01 DRC amounts other than outlier payments for discharges occurring prior to to Ctober 1 DRC amounts other than outlier payments for discharges occurring prior to Ctober 1 1.02 1.302,014 1.302,014 1.302,014 1.302,014 1.002 1.302,014 1.302,014 1.002 1.008 1			0	1.00	2.00	3. 00	4. 00	
discharges occurring prior to October 1 1.02 1.302,014 1.302,014 1.02 1.02 1.02 1.03 1.02 1.03	1. 00	DRG amounts other than outlier payments	1. 00					1. 00
1.02 0.08C amounts other than outlier payments for discharges occurring on or after October 1 1.03 0 0 0 0 0 1.03 1.02 1.03 1.02 1.03 0 0 0 0 0 1.03 1.04 1.02 1.03 1.04 1.02 1.03 1.04 1.02 1.05 1.05 1.04 1.05 1.	1.01	DRG amounts other than outlier payments for	1. 01	4, 115, 280	4, 115, 280		4, 115, 280	1. 01
discharges occurring on or after October 1 1.03 0.0 0.0 0.0 0.0 1.03 1.03 1.05 1		discharges occurring prior to October 1						
1.03	1.02	DRG amounts other than outlier payments for	1. 02	1, 302, 014		1, 302, 014	1, 302, 014	1. 02
Tor Model 4 BPCI occurring prior to October 1		discharges occurring on or after October 1						
1.04 DRG for Federal specific operating payment 1.04 0 0 0 0 0 0 0 0 0	1.03	DRG for Federal specific operating payment	1. 03	0	0		0	1.03
For Model A BPCI occurring on or after		for Model 4 BPCI occurring prior to October						
For Model A BPCI occurring on or after		1						
October 1	1.04	DRG for Federal specific operating payment	1.04	0		0	0	1. 04
2.00		for Model 4 BPCI occurring on or after						
instructions 0								
2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 0 0 0 0 0 0	2.00	Outlier payments for discharges (see	2.00	2, 030, 923	799, 406	1, 231, 517	2, 030, 923	2. 00
BPCI		· · · · · · · · · · · · · · · · · · ·						
3.00 Operating outlier reconciliation 2.01 0 0 0 0 0 0 4.00	2. 01		2. 02	0	0	0	0	2. 01
A 00 Managed care simulated payments								
Indirect Medical Education Adjustment				1	Ĭ	· ·		
S.00 Amount from Worksheet E, Part A, Line 21 21.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	4. 00		3. 00	0	0	0	0	4. 00
See instructions Canal C								
Location 5. 00		21. 00	0. 000000	0. 000000	0. 000000		5. 00	
ME payment adjustment for managed care (see 22.01 0 0 0 0 0 0 6.01				_	_	_	_	
Instructions				l e				
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA The payment adjustment factor (see	6. 01		22. 01	0	0	0	0	6. 01
7.00 IME payment adjustment factor (see 27.00 0.0000000 0.0000000 0.0000000 0.00000000								
Instructions IME adjustment (see instructions) 28.00 0 0 0 0 0 0 8.00	7.00					0.00000		7.00
8.00 IME adjustment (see instructions) 28.00 0 0 0 0 0 8.00 8.01 IME payment adjustment add on for managed 28.01 0 0 0 0 0 0 8.01 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 9.01 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 0 0 0 0 0 0 0 10 Disproportionate Share Adjustment 0 0 0 0 0 0 0 10 Disproportionate Share Adjustment 0 0 0 0 0 0 0 10 Disproportionate Share Adjustment 0 0 0 0 0 0 0 0 10 Disproportionate share adjustment (see 34.00 123,785 94,034 29,751 123,785 11.00 11 Disproportionate share adjustment (see 36.00 6 4 2 6 11.01 12 Disproportionate share adjustment (see 36.00 6 4 2 6 11.01 13 Disproportionate share adjustment (see 36.00 6 4 2 6 11.01 14 Disproportionate share adjustment (see 46.00 0 0 0 0 0 0 15 Disproportionate share adjustment (see 46.00 0 0 0 0 0 0 16 Disproportionate share adjustment (see 46.00 0 0 0 0 0 0 0 17 Disproportionate share adjustment (see 46.00 0 0 0 0 0 0 0 0 18 Disproportionate share adjustment (see 46.00 0 0 0 0 0 0 0 0 18 Disproportionate share adjustment (see 46.00 0 0 0 0 0 0 0 0 0	7.00		27.00	0.000000	0.000000	0.000000		7.00
IME payment adjustment add on for managed care (see instructions) 29.00 0 0 0 0 0 0 0 0 0	0 00		20.00	_	_	0		0.00
Care (see instructions)						· ·		
9.00 Total IME payment (sum of lines 6 and 8)	8.01		28.01	0	0	U	U	8.01
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see 34.00 123,785 94,034 29,751 123,785 11.00 instructions) 11.01 Disproportionate share adjustment (see 36.00 6 4 2 6 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 7,572,008 5,008,724 2,563,284 7,572,008 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 0 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 7,572,008 5,008,724 2,563,284 7,572,008 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00		20.00	_	_	0		0.00
I ines 6.01 and 8.01 Disproportionate Share Adjustment 10.00 All lowable of disproportionate share percentage 33.00 0.0914 0.0914 0.0914 0.0914 10.00 10.00 10.00 11.00 123,785 94,034 29,751 123,785 11.00 11.01 11.0				·	0	0	-	
Disproportionate Share Adjustment	9.01		29.01	U	٥	U	U	9.01
10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see 34.00 123,785 94,034 29,751 123,785 11.00 123,785 11.00 123,785 123,785 11.00 123,785 123,785 11.00 123,785 11.00 123,785 123,785 11.00 123,785 123,785 11.00 123,785 123,785 11.00 123,785 123,785 11.00 123,785 123,785 11.00 123,785 123,785 123,785 123,785 123,785 11.00 123,785								
11.00 Disproportionate share adjustment (see 34.00 123,785 94,034 29,751 123,785 11.00 1.	10 00		33 00	0.0914	0.0914	0.0914		10 00
11. 00 Disproportionate share adjustment (see instructions) 11. 01 Uncompensated care payments 12. 00 Total ESRD additional payment (see instructions) 13. 00 Subtotal (see instructions) 14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15. 00 Total payment for inpatient operating costs (see instructions) 16. 00 Payment for inpatient program capital special add-on payments for new technologies 54. 00 17. 01 Net organ acquisition cost 18. 00 Capital outlier reconciliation adjustment (see 34. 00 and MDH) 18. 00 Capital outlier reconciliation adjustment 93. 00 19. 00 10. 01 123, 785	10.00		33.00	0.0714	0.0714	0.0714		10.00
11. 01 Uncompensated care payments 36.00 6 4 2 6 11. 01	11 00		34 00	123 785	94 034	29 751	123 785	11 00
11.01 Uncompensated care payments 36.00 6 4 2 6 11.01			01.00	120,700	, ,, 00 .	277701	120,700	
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see	11. 01		36.00	6	4	2	6	11. 01
12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 7,572,008 5,008,724 2,563,284 7,572,008 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 7,572,008 5,008,724 2,563,284 7,572,008 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 18.00			D beneficiary	di scharges				
13.00 Subtotal (see instructions) 47.00 7,572,008 5,008,724 2,563,284 7,572,008 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 49.00 7,572,008 5,008,724 2,563,284 7,572,008 15.00 15.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 18.00 18.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 10.00 10.00 19.00 19.00 10.00 10.00 19.00 19.00 10.00 10.00 19.00 10.00 10.00 19.00 10.00 10.00 10.00 10.00 10.	12.00				0	0	0	12.00
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital solution cost (see instructions) 16.00 Special add-on payments for new technologies solution cost (replaced devices for applicable MS-DRGs) 18.00 Capital outlier reconciliation adjustment amount (see instructions) 48.00 0 0 0 0 0 0 14.00 0 0 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	13.00	Subtotal (see instructions)	47.00	7, 572, 008	5, 008, 724	2, 563, 284	7, 572, 008	13.00
instructions 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19	14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 18.00 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Total payment for inpatient operating costs		and MDH, small rural hospitals only.) (see						
16.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 0 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 17.02 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 18.00		instructions)						
16.00 Payment for inpatient program capital 50.00 755,749 419,719 336,030 755,749 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Oredits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 17.02 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 18.00	15.00	Total payment for inpatient operating costs	49.00	7, 572, 008	5, 008, 724	2, 563, 284	7, 572, 008	15.00
17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions) 54.00 0 0 0 0 0 17.00 17.00 17.00 17.00 17.00 0 0 0 0 0 0 18.00		(see instructions)						
17. 01 Net organ acquisition cost 17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 17. 01 00 00 00 00 00 00 00 00 00 00 00 00 0				755, 749	419, 719	336, 030	755, 749	
17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 68. 00 0 0 17. 02 18. 00 0 0 18. 00	17. 00		54.00	0	0	0	0	17. 00
replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 18.00	17. 01	Net organ acquisition cost						17. 01
18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 18.00 amount (see instructions)	17. 02		68.00	0	0	0	0	17. 02
amount (see instructions)								
	18. 00		93.00	0	0	0	0	18. 00
19. 00 SUBIOTAL 5, 428, 443 2, 899, 314 8, 327, 757 19. 00								
	19. 00	SUBTOTAL			5, 428, 443	2, 899, 314	8, 327, 757	19. 00

lealth Financial Systems	MONROE HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5	Provi der C		Peri od: From 01/01/2016 To 12/31/2016		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 20.01 Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	432, 630 0	328, 12	104, 510 0 0	432, 630 0	20. 00 20. 01
21.00 Capital DRG outlier payments 21.01 Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	323, 119 0	91, 59	9 231, 520 0 0	323, 119 0	
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	755, 749	419, 71	9 336, 030	755, 749	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
		A)	0.00	0.00	4.00	
27. 00	0	1.00	2. 00	3. 00	4. 00	27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	
29.00 Low volume adjustment on or after October 1	70. 97				0	
0.00 HVBP payment adjustment (see instructions)	70. 97				0	
0.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 0
1.00 HRR adjustment (see instructions)	70. 94	l 0		0	0	31.0
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		o o	0	
					(Amt to Wkst	

1.00

Ν

0

70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

2.00

(Amt. to Wkst. E, Pt. A) 4.00

0 32.00

3. 00

0

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0183	Peri od: Worksheet E From 01/01/2016 Part B To 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am

PART. 8 - MEDICAL AND OTHER HEALTH SERVICES 1.00				10 12/31/2016	5/27/2017 10:	
DOURT B						40 aiii
Medical and other services (see instructions)			1 2 2			
Modical and other services (see instructions)					1. 00	
100 Modical and other services reinbursed under OPPS (see instructions) 2, 426, 429 2, 1, 753, 829 3.						
1,753, RPP 3.00 17,753, RPP 3.10 17,754, RPP 3.10 3	1.00					1.00
172,475	2.00	1	tions)			
Comparison Com		1 . 3				•
1.00 Line 2 times 1 ine 5 0 0 0 0 0 0 0 0 0		, , ,	ctions)			
0.00 Sum of Tine 3 plus line 4 divided by line 6 0.00 7		, , , , , , , , , , , , , , , , , , , ,	ctions)			
0.00 Ancillary service of their pass through costs from Wist. D. Pt. IV, col. 13, Iline 200 0 9, 0 0 0 0 0 0 0 0 0 0						
0.00 0.00	8. 00					ı
0.00 Organ acqui sittinos 0.00 Organ acqui sittinos 1.00 Organ acqui sittinos 1.00 Organ acqui sittinos 1.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 69) 3.00 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 110 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 110 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 110 Organ acqui sittino charges (From West. D-4, Pt. III, col. 4, line 110 Organ acqui sittino charges (From West. D-4, III, col. 4, line 110 Organ acqui sittino charges (From West. D-4, III, col. 4, line 110 Organ acqui sittino charges (From West. D-4, III, col. 4, line 3, line 110 Organ acqui sittino charges (From West. D-4, III, col. 4, line 3, line 110 Organ acqui sittino charges (From West. D-4, III, col	9. 00	1 3 1	IV. col. 13. line 200			9. 00
1.00 Total cost (sun of lines 1 and 10) (see instructions) 102 11.0	10.00		,			10.00
Reasonable charges 36	11.00	Total cost (sum of lines 1 and 10) (see instructions)			102	11.00
2.00 Ancillary service charges 366 12.0		COMPUTATION OF LESSER OF COST OR CHARGES				
1.00 Organ acquisition charges (from Wist. D-4, Pt. III., col. 4, line 69) 0 13.0						
1.00 Total reasonable charges (sum of lines 12 and 13) 366 14.	12. 00	1				1
Country Charges Country Ch	13. 00		ine 69)			13. 00
5.00 Aggregate amount actually collected from patients ilable for payment for services on a charge basis 0 15. 6.00 Amounts that would have been realized from patients ilable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 0 16. 7.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 8.00 Ital customary charges (see instructions) 0.000000 9.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions) 264 1.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions) 102 1.01 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0 2.00 Interns and residents (see instructions) 0 2.01 (cost of physicians' services in a teaching hospital (see instructions) 0 2.02 (cost of physicians' services in a teaching hospital (see instructions) 0 2.01 (cost of physicians' services in a teaching hospital (see instructions) 0 2.02 (cost of physicians' services in a teaching hospital (see instructions) 0 2.00 Deductibles and coinsurance (for CAH, see instructions) 0 2.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 1 2.00 Excess of payment (see	14. 00				366	14. 00
10.0	15 00		normant for complete on	a abanga basi s	0	1 1 5 00
had such payment been made in accordance with 42 CFR §413.13(e)		, , , , , , , , , , , , , , , , , , , ,	. 3	~		
2.00 Nation of Filine 15 to line 16 (not to exceed 1.000000) 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.000000 1.0000000 1.0000000 1.0000000 1.0000000 1.00000000 1.0000000 1.00000000 1.000000000 1.0000000000	10.00			ii a ciiai gebasi s	U	10.00
3.00 Total customary charges (see instructions) 366 18.1	17. 00				0. 000000	17. 00
2.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 2.04 10.0	18. 00	· · · · · · · · · · · · · · · · · · ·				
Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 2.0 (19.00		ly if line 18 exceeds li	ne 11) (see	264	19.00
Instructions 1.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 1.02 21.0 2.00 Interns and residents (see instructions) 0.02.0 23.0 23.0 25.0 2		instructions)		, ,		
Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 102 21.0	20. 00		ly if line 11 exceeds li	ne 18) (see	0	20.00
Interns and residents (see instructions)						
Cost of physicians' services in a teaching hospital (see instructions) 1, 926, 304	21. 00		e instructions)			
Total prospective payment (sum of lines 3, 4, 8 and 9) 1,926,304 24.0		1	munti ana)			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT COMPUTATION OF RELIMBURSEMENT COMPUTATION OF			ructions)		-	
Deductibles and coinsurance (for CAH, see instructions)	24.00				1, 720, 304	24.00
200 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 379, 882 26.	25. 00				0	25. 00
Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 1,546,524 27.0	26. 00	,	r CAH, see instructions)		379, 882	26.00
8.00 Direct graduate medical education payments (from Wkst. E-4, line 50) CRRD direct medical education costs (from Wkst. E-4, line 36) O 29.0 O 2	27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) r	plus the sum of lines 22	and 23] (see	1, 546, 524	27.00
Subtotal (sum of lines 27 through 29)		1				
0.00 Subtotal (sum of lines 27 through 29) 1,546,524 30.0 1,546,524 31.0 2.00 2.00 Subtotal (line 30 minus line 31) 1,546,524 31.0 3	28. 00		ine 50)			28. 00
1.00	29. 00	1				29. 00
2.00 Subtotal (line 30 minus line 31) 1,546,524 32.0 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 3.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.0 (3.00 composite rate ESRD (from Wkst. 1-5, line 11) 0 34.0 (4.00 composite rate ESRD (from Wkst. 1-5, line 11) 0 34.0 (4.00 composite rate ESRD (from Wkst. 1-5, line 11) 0 34.0 (4.00 composite rate ESRD (from Wkst. 1-5, line 11) 0 34.0 (4.00 composite rate ESRD (from Wkst. 1-5, line 11) 0 34.0 (4.00 composite rate instructions) 0 36.0 (4.00 composite rate instructions)	30.00	,				30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 3.00 Composite rate ESRD (from Wkst. 1-5, line 11) 4.00 Allowable bad debts (see instructions) 5.00 Adjusted reimbursable bad debts (see instructions) 5.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 8.00 MSP-LCC reconciliation amount from PS&R 9.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.50 Pioneer ACO demonstration payment adjustment (see instructions) 9.99 Recovery of Accelerated Depreciation 9.99 Recovery of Accelerated Depreciation 9.00 Subtotal (see instructions) 1.546,524 9.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 9.99 Recovery of Accelerated Depreciation 9.90 Subtotal (see instructions) 9.90 Subtotal (see instructions) 9.90 Interim payments 9.00 Interim payments 9.00 Tentative settlement (for contractors use only) 9.00 Tentative settlement (see instructions) 9.00 Original outlier amount (see instructions) 9.00 Original outlier amount (see instructions) 9.00 Outlier reconciliation adjustment amount (see instructions) 9.00 Outlier reconciliation adjustment amount (see instructions) 9.00 Outlier reconciliation adjustment amount (see instructions) 9.00 Outlier of Money (see instructions) 9.00 Outlier of Money (see instructions) 9.01 Outlier of Money (see instructions) 9.02 Outlier of Money (see instructions) 9.03 Outlier of Money (see instructions)					-	1
3.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 31.0 0 1.0 0 1.0 0 1.0 0 1.0 0 0 1.0 0 0 0 0 0 0 0 0 0	32.00		rec)		1, 340, 324	32.00
Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Bubtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) 1, 546, 524 0, 39. 9 9. 99 RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) 1, 546, 524 1, 5	33. 00		563)		0	33.00
Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) NSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see instructions) PRECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Subtotal (see ins	34. 00	1				34.00
Subtotal (see instructions) 8.00 MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pi oneer ACO demonstration payment adjustment (see instructions) 9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9.99 RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) 1, 546, 524 0.00 1, 546, 524 0.00 1, 546, 524 0.01 1, 546, 524 0.02 1, 546, 524 0.03 39.9	35. 00				0	35.00
8.00 MSP-LCC reconciliation amount from PS&R 0 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.50 Pioneer ACO demonstration payment adjustment (see instructions) 9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9.99 RECOVERY OF ACCELERATED DEPRECIATION 0.00 Subtotal (see instructions) 1, 546, 524 40.0 0.01 Sequestration adjustment (see instructions) 1, 546, 524 40.0 1, 515, 560 41.0 1, 500 Balance due provider/program (see instructions) 1, 515, 560 41.0 1, 500 Balance due provider/program (see instructions) 2, 500 Balance due provider/program (see instructions) 3, 500 Balance due provider/program (see instructions) 4, 60 Balance due provider/program (see instructions) 5, 500 Balance due provider/program (see instructions) 6, 500 Balance due provider/program (see instructions) 7, 500 Balance due provider/program (see instructions) 9, 500 Balance du	36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	36.00
9.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.50 Pioneer ACO demonstration payment adjustment (see instructions) 9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9.99 RECOVERY OF ACCELERATED DEPRECIATION 0.00 Subtotal (see instructions) 1,546,524 40.0 1,00 Interim payments 2.00 Tentative settlement (for contractors use only) 3.00 Balance due provider/program (see instructions) 4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5}15.2\$ TO BE COMPLETED BY CONTRACTOR 0.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0.00 Time Value of Money (see instructions)	37. 00				1, 546, 524	37.00
Pioneer ACO demonstration payment adjustment (see instructions) 9. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9. 99 RECOVERY OF ACCELERATED DEPRECIATION 0. 00 Subtotal (see instructions) 0. 01 Sequestration adjustment (see instructions) 1, 546, 524 40.0 1, 546, 524 40.0 1, 515, 560 41.0 2. 00 Tentative settlement (for contractors use only) 3. 00 Balance due provider/program (see instructions) 4. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5}15.2\$ TO BE COMPLETED BY CONTRACTOR 0. 00 Outlier reconciliation adjustment amount (see instructions) 1. 00 Uniting reconciliation adjustment amount (see instructions) 1. 00 The rate used to calculate the Time Value of Money 1. 00 Time Value of Money (see instructions) 0 93.0 39.9 39.9 39.9 39.9 39.9 39.9 30	38. 00	MSP-LCC reconciliation amount from PS&R			0	38.00
9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9.99 RECOVERY OF ACCELERATED DEPRECIATION 0.00 Subtotal (see instructions) 1,546,524 40.0 0.01 Sequestration adjustment (see instructions) 1,515,560 41.0 2.00 Tentative settlement (for contractors use only) 3.00 Balance due provider/program (see instructions) 4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15.2 TO BE COMPLETED BY CONTRACTOR 0.00 Outlier reconciliation adjustment amount (see instructions) 1.00 Universe used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 39.0 39.0 39.0 39.0 30	39. 00					39.00
RECOVERY OF ACCELERATED DEPRECIATION 0.00 Subtotal (see instructions) 1,546,524 40.0 1,546,524 40.0 30,930 40.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,560 41.0 1,515,2 1,515,	39. 50	, , , , , , , , , , , , , , , , , , , ,	•			39. 50
Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{115.2}{2}\$ To BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 1,546,524 40.0 30,930 40.0 1,515,560 41.0 42.0 43.0 44.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0	39. 98	·	ced devices (see instruc	tions)		39. 98
Sequestration adjustment (see instructions) 1. 00 Interim payments 2. 00 Tentative settlement (for contractors use only) 3. 00 Balance due provider/program (see instructions) 4. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15. 2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 0. 00 Outlier reconciliation adjustment amount (see instructions) 1. 00 Universe of the followable of the provided of the payon of t	39. 99					39. 99
1.00 Interim payments 2.00 Tentative settlement (for contractors use only) 3.00 Balance due provider/program (see instructions) 4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\fra	40.00	· · · · · · · · · · · · · · · · · · ·				40.00
Tentative settlement (for contractors use only) 3. 00 Balance due provider/program (see instructions) 4. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5}115.2\$ To BE COMPLETED BY CONTRACTOR 0. 00 Original outlier amount (see instructions) 0. 01 Utilier reconciliation adjustment amount (see instructions) 1. 00 Utilier reconciliation adjustment amount (see instructions) 2. 00 The rate used to calculate the Time Value of Money 3. 00 Time Value of Money (see instructions) 0. 93. 0						
3.00 Balance due provider/program (see instructions) 4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 9.10 BE COMPLETED BY CONTRACTOR 0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 93.0						
4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{9115.2}}{\text{10 BE COMPLETED BY CONTRACTOR}}\$ 0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 93.00	43. 00	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				43.00
\$115.2 TO BE COMPLETED BY CONTRACTOR 0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 93.0	44. 00					1
TO BE COMPLETED BY CONTRACTOR 0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 93.0	00					50
0.00 Original outlier amount (see instructions) 0 90.0 1.00 Outlier reconciliation adjustment amount (see instructions) 0 91.0 2.00 The rate used to calculate the Time Value of Money 0.00 92.0 3.00 Time Value of Money (see instructions) 0 93.0						1
2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0.00 92.0	90.00				0	90.00
3.00 Time Value of Money (see instructions) 0 93.0	91. 00	,				
4.00 lotal (sum of lines 91 and 93) 0 94.0		1 · · · · · · · · · · · · · · · · · · ·				
	94. 00	lotal (sum of lines 91 and 93)			0	94.00

Peri od: Worksheet E-1
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/27/2017 10:46 am Provider CCN: 15-0183

					5/27/2017 10: 2	46 am_
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A		⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I=	1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		7, 456, 566		1, 515, 560	1.00
2.00	Interim payments payable on individual bills, either		(0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			-1	_	
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3. 02					0	3. 02 3. 03
3. 03 3. 04					0	3. 03
3.04						3. 04
3.03	Provider to Program			21		3. 03
3. 50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51					0	3. 51
3.52			(0	3. 52
3.53			(O .	0	3. 53
3.54					0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(D	0	3. 99
4 00	3. 50-3. 98)		7 457 57	,	1 515 570	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		7, 456, 566		1, 515, 560	4. 00
	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			1		
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02 5. 03					0 0	5. 02
5.03	Provider to Program		()	0	5. 03
5. 50	TENTATI VE TO PROGRAM		(1 0	5. 50
5. 51	TENTITY E TO TROOM WIT				l ő	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		75 /5			. 01
6. 01	SETTLEMENT TO PROVIDER		75, 65		34	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		7, 532, 22		1, 515, 594	6. 02 7. 00
7.00	Total medicale program Habitity (see Histractions)		1,002,22	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00
	·					

Heal th	Financial Systems MONROE HOS	PI TAL	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0183 Period: Worksheet E-From 01/01/2016 Part II					
			To 12/31/2016	Date/Time Prep		
		T: +1 o V/////	Hooni tol	5/27/2017 10: 2	46 am_	
	<u> </u>	Title XVIII	Hospi tal	PPS		
				1.00		
	TO DE COMPLETED BY CONTRACTOR FOR MONETANDARD COST REPORTS			1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	1				
1 00			. 14	1, 486	1. 00	
1. 00 2. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		2 14			
3.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	5-12		2, 451	2. 00 3. 00	
	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2 12		E 0E0		
4. 00 5. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	5-12		5, 058 132, 684, 836		
	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	ino 20		132,004,030		
6. 00 7. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I		Wkat Ca Dt I	١	6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified Hir technology	WKSt. 3-2, Pt. I	١	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			250, 466	8. 00	
9. 00	Sequestration adjustment amount (see instructions)			5, 009		
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		245, 457		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00 Initial/interim HIT payment adjustment (see instructions)						
	Other Adjustment (specify)			اه	30. 00 31. 00	
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)	245, 457		
		, ,	,			

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0183	Peri od: Worksheet E-3 From 01/01/2016 Part VII To 12/31/2016 Date/Time Prepared:

		-	Го 12/31/2016	Date/Time Prep 5/27/2017 10:4	pared: 46 am
		Title XIX	Hospi tal	PPS	10 4
		<u> </u>	Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			2, 438, 787	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	2, 438, 787	4. 00
5.00	Inpatient primary payer payments		0	_	5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	2, 438, 787	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges Routine service charges		672, 621		8. 00
9. 00	Ancillary service charges		5, 292, 006	13, 204, 553	9. 00
10.00	Organ acquisition charges, net of revenue		3, 272, 000	13, 204, 333	10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		5, 964, 627	13, 204, 553	
	CUSTOMARY CHARGES		27 . 2 . 7 2 1		
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	9			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
16.00	Total customary charges (see instructions)		5, 964, 627	13, 204, 553	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	5, 964, 627	10, 765, 766	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 1 exceeds line	0	0	18. 00
10.00	16) (see instructions)	TI TITLE 4 EXCEEDS TITLE	٩	O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0	2, 438, 787	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
	Subtotal (sum of lines 22 through 26)		0	0	27. 00 28. 00
28. 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		0	2 429 797	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		l o	2, 438, 787	29.00
30 00	Excess of reasonable cost (from line 18)		O	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		o	2, 438, 787	31. 00
32. 00	Deducti bl es		o	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34.00	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)	0	2, 438, 787	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00			0	2, 438, 787	
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00			0	2, 438, 787	40.00
41. 00	Interim payments		0	0	41.00
42. 00 43. 00	Balance due provider/program (line 40 minus line 41)	o with CMS Dub 15 2	0	2, 438, 787 0	42. 00 43. 00
43.00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	E WILLI CINS PUD 15-2,		U	43.00
	1		1	ı	ı

Health Financial Systems

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

Provider CCN: 15-0183 Period: From 01/0

oni y)				12/01/2010	5/27/2017 10:	
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	3, 852, 626	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3. 00	Notes receivable	0	0	0	0	
4.00	Accounts receivable	97, 028, 218		0	0	
5. 00 6. 00	Other receivable	6, 401, 176		0	0	
7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-87, 593, 766 1, 161, 125		0	0	1
8.00	Prepaid expenses	201, 706		0	0	1
9. 00	Other current assets	80, 535		0	0	
10.00	Due from other funds	0		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	21, 131, 620	0	0	0	11. 00
	FIXED ASSETS	1				
12.00	Land	1, 300, 000			0	1
13.00	Land improvements	0	1	0	0	
14. 00 15. 00	Accumulated depreciation Buildings	8, 000, 000	0	0	0	1
16. 00	Accumulated depreciation	-1, 066, 666		0	0	1
17. 00	Leasehold improvements	1, 142, 471	0	0	0	17. 00
18. 00	Accumulated depreciation	-146, 495		0	0	1
19.00	Fi xed equipment	6, 648, 766	0	0	0	19. 00
20.00	Accumulated depreciation	-1, 802, 770	0	0	0	20. 00
21. 00	Automobiles and trucks	0		0	0	
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	868, 084		0	0	1
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-535, 922	0	0	0	24. 00 25. 00
26. 00	Accumulated depreciation		0	0	0	26.00
27. 00	HIT designated Assets		0	0	0	1
28. 00	Accumulated depreciation		Ō	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	14, 407, 468	0	0	0	30.00
	OTHER ASSETS	1	1			
31.00	Investments	0	_	0	0	
32. 00 33. 00	Deposits on leases Due from owners/officers	0	0	0	0	32. 00 33. 00
34. 00	Other assets	532, 386	0	0	0	1
35. 00	Total other assets (sum of lines 31-34)	532, 386		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	36, 071, 474		0	0	1
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	2, 338, 328			0	1
38. 00	Salaries, wages, and fees payable	571, 043		0	0	
39. 00	Payroll taxes payable	249, 434	0	0	0	1
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	926, 311 53, 639	0	0	0	40.00
41.00	Accel erated payments	33, 639	0	U	U	42.00
43. 00	Due to other funds	23, 117, 626	0	0	0	1
44. 00	Other current liabilities	1, 484, 465		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	28, 740, 846	0	0	0	45. 00
	LONG TERM LIABILITIES	1				
46.00	Mortgage payable	5, 000, 000		0	0	
47. 00	Notes payable	460, 168		0	0	1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	12, 031, 148	0	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	17, 491, 316		0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	46, 232, 162			0	
	CAPITAL ACCOUNTS	,,				
52.00	General fund balance	-10, 160, 688				52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	_	56.00
57. 00 58. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	-10, 160, 688	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	36, 071, 474	•	o	0	60.00
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES MONROE HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0183

					То	12/31/2016	Date/Time Prep 5/27/2017 10:4	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	TO GIII
		1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		3, 346, 263			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1, 612, 441					2. 00
3.00	Total (sum of line 1 and line 2)		1, 733, 822			0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00	PRI OR PERI OD ADJ	-11, 894, 510			0		0	5. 00
6. 00 7. 00		0			0		0	6. 00 7. 00
8.00					0			8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		-11, 894, 510		Ĭ	0		10. 00
11.00	Subtotal (line 3 plus line 10)		-10, 160, 688			0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13.00		0			0		0	13.00
14. 00		0			0		0	
15. 00		0			0		0	15. 00
16. 00 17. 00		0			0		0	16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)	0	0		U	0	U	17.00
19. 00	Fund balance at end of period per balance		-10, 160, 688			0		19. 00
17.00	sheet (line 11 minus line 18)		10, 100, 000			· ·		17.00
		Endowment Fund	PI ant	Fund				
		/ 00	7.00	0.00				
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0			1, 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				J			2.00
3.00	Total (sum of line 1 and line 2)	O			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00	PRIOR PERIOD ADJ		0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		U		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0			10.00
12. 00	Deductions (debit adjustments) (specify)		0		ď			12. 00
13. 00			0					13. 00
14.00			0					14.00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00	T + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 +		0					17. 00
18.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0			18. 00 19. 00
19. 00	sheet (line 11 minus line 18)	١			U			19.00
	Isheet (The II milius The 10)	ı I		ı	1			

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0183

			'	0 12/31/2010	5/27/2017 10: 4	
	Cost Center Description	Inpatien	t	Outpati ent	Total	
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal	5, 473,	244		5, 473, 244	1.00
2.00	SUBPROVI DER - I PF		0		0	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER					4.00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY		0		0	7. 00
8.00	NURSING FACILITY		0		0	8. 00
9. 00	OTHER LONG TERM CARE		0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 473,	244		5, 473, 244	
	Intensive Care Type Inpatient Hospital Services	, -,,			2,, =	
11. 00	INTENSIVE CARE UNIT	1, 996,	368		1, 996, 368	11. 00
12. 00	CORONARY CARE UNIT	1, 112,	0		0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		0		0	13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT		0		0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)		Ŭ		ŭ.	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	nes 1, 996,	368		1, 996, 368	
	11-15)	1,776,	000		1, ,,0,000	.0.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 469,	612		7, 469, 612	17. 00
18. 00	Ancillary services	49, 232,		75, 982, 445	125, 215, 225	18. 00
19. 00	Outpatient services	17, 202,	0	0	0	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		Ū	0	0	22. 00
23. 00	AMBULANCE SERVICES		0	0	0	23. 00
24. 00	CMHC		Ü	0	0	24. 00
24. 10	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	25. 00
26. 00	HOSPI CE		0	0	0	26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst. 56,702,	392	75, 982, 445	132, 684, 837	28. 00
20.00	G-3, line 1)	3 m(31.	0,2	70, 702, 110	102, 001, 007	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			33, 006, 318		29. 00
30. 00	ADD (SPECIFY)		0	,,		30. 00
31. 00	(0. 20)		0			31. 00
32. 00			0			32.00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		Ŭ	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	Ĭ		37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		J	n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		33, 006, 318		43. 00
	to Wkst. G-3, line 4)	(33, 333, 610		.0.00
	1	1			'	

111-41-	Figure in Contains	OCDI TAL	1 - 1 -	u of Form CMS-2	NEED 10
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0183 Period: From 01/01/2016				
	To 12/31/2016				
1 00	T			1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			132, 684, 837	1.00
2.00	Less contractual allowances and discounts on patients' acco	ounts		102, 813, 474	2.00
3. 00 4. 00	Net patient revenues (line 1 minus line 2)			29, 871, 363	3. 00
4. 00 5. 00	Less total operating expenses (from Wkst. G-2, Part II, III	ne 43)		33, 006, 318	
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-3, 134, 955	5. 00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			911	7. 00
8. 00	Revenues from telephone and other miscellaneous communicati	ion services		0	8. 00
9. 00	Revenue from television and radio service	1011 301 11 003		0	9. 00
10.00	Purchase di scounts			0	10. 00
11. 00				0	11. 00
12. 00				0	12. 00
13. 00				0	13. 00
14. 00	1			122, 497	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16. 00		r than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients	·		0	17.00
18. 00	,			562	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MEANI NGFUL USE FUNDS - EHR			1, 400, 000	24.00
24. 01	OTHER INCOME			3, 605	24. 01
24. 02	PY CORRECTION			0	24.02
25.00	Total other income (sum of lines 6-24)			1, 527, 575	25.00
26.00	Total (line 5 plus line 25)			-1, 607, 380	26.00
27. 00	OTHER NON-OPERATING REV			5, 061	27.00
	Total other expenses (sum of line 27 and subscripts)			5, 061	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28))		-1, 612, 441	29. 00

	Financial Systems MONROE H				
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0183	Peri od: From 01/01/2016 To 12/31/2016		
	Title XVIII Hospital				+0 aiii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier				1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2.00	Capital DRG outlier payments			323, 119	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			13. 82	
4.00	Number of interns & residents (see instructions)			0.00	
5. 00 6. 00	Indirect medical education percentage (see instructions)	the cum of lines 1 and 1 01	L calumna 1 and	0.00	
6.00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)	the sum of fines fand f. of	i, corumns i and	0	6. 0
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet E	E, part A line	0.00	7.0
8. 00	Percentage of Medicaid patient days to total days (see instructions)			0.00	8.0
9. 00				0.00	
10.00				0.00	10.0
11. 00	Disproportionate share adjustment (see instructions)	,		0	ı
12. 00				755, 749	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.0
3.00	Total inpatient program capital cost (line 1 plus line 2)	,		0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.0
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 0
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	2. 0
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	0.0
6.00	Percentage adjustment for extraordinary circumstances (see			0.00	
7.00	Adjustment to capital minimum payment level for extraordin	ary circumstances (line 2 >	(line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as ap			0	
10.00	Current year comparison of capital minimum payment level t			0	
	Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14)		•	0	
	Net comparison of capital minimum payment level to capital			0	
12. 00			7)	0	
12. 00 13. 00	Current year exception payment (if line 12 is positive, en				
12. 00 13. 00	Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove			0	14.0
11. 00 12. 00 13. 00 14. 00	Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line)	r capital payment for the f		0	
12. 00 13. 00	Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove	r capital payment for the finstructions)			15. 0