PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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 CHIEF FINANCIAL 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 01/01/2017 and ending 12/31/2017 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 regul ati ons.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gried)				
	Officer or	Administrator	of Provider(s)	
	0111001 01	Admi III Strator	01 11011401(3)	
Title				
Date				

number of times reopened = 0-9.

			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	28, 712	6	0	2, 209, 653	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	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	28, 712	6	0	2, 209, 653	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. 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. 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.

23.00	will cir method is used to determine medical didys on in	nes 24 anu,	or 25 berc	JW? III COLUI		ગ	IN	23.00		
	1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the									
	method of identifying the days in this cost reporting	period di	fferent fro	om the metho	od					
	used in the prior cost reporting period? In column 2	Ž, enter "Y	for yes o	or "N" for r	no.					
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther			
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d			
		pai d days	eligible	Medi cai d	Medi cai d		days			
			unpai d	paid days	eligible					
			days		unpai d					
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00			
24 00	If this provider is an IPPS hospital, enter the	77	2.00	3.00	4.00	5.00		24. 00		
24.00	in-state Medicaid paid days in column 1, in-state	' '	0		١	317	0	24.00		
	Medicaid eligible unpaid days in column 2,									
	out-of-state Medicaid paid days in column 3,									
	out-of-state Medicaid eligible unpaid days in column									
	4, Medicaid HMO paid and eligible but unpaid days in									
	column 5, and other Medicaid days in column 6.									
25.00	If this provider is an IRF, enter the in-state	o	0	0	l o	0		25. 00		
	Medicaid paid days in column 1, the in-state									
	Medicaid eligible unpaid days in column 2,									
	out-of-state Medicaid days in column 3, out-of-state									
	Medicaid eligible unpaid days in column 4, Medicaid									
	HMO paid and eligible but unpaid days in column 5.							l		

11000	Financial Systems		SPI TAL		In Lie	u of Form CMS-2	2552-10	
HUSPI T	FAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/19/2018 11:0	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
			1. 00	2. 00	3. 00	4.00	5. 00	
	surgery allopathic and/or osteop current cost reporting period. (s	eathic FTEs in the see instructions).						61. 04
61. 05	Enter the difference between the and/or general surgery FTEs and primary care and/or general surgent 61.04 minus line 61.03). (see in	the current year's pery FTE counts (line						61. 05
61. 06	Enter the amount of ACA \$5503 aw used for cap relief and/or FTEs care or general surgery. (see in	vard that is being that are nonprimary						61. 06
		ogram Name	Program Code	FTE Count	Direct GME FTE Count			
/1 10	Of the FTFe in line (1 OF eneci	fix analy navy navagram		1. 00	2. 00	3.00	4.00	61. 10
61. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instruction of the program name. Enter program code. Enter in column 3, unweighted count. Enter in column FTE unweighted count.	er of FTE residents cuctions) Enter in er in column 2, the the IME FTE				0.00	0.00	61. 10
61. 20	of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog- instructions) Enter in column 1, Enter in column 2, the program of 3, the IME FTE unweighted count. the direct GME FTE unweighted count.	he number of FTE gram. (see the program name. code. Enter in column Enter in column 4,				0.00	0.00	61. 20
							1.00	
42.00	ACA Provisions Affecting the Hea					ried for which	0.00	42.00
62.00	Enter the number of FTE resident your hospital received HRSA PCRE			i in this cost	reporting pe	riod for which	0.00	62. 00
62. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (s	<u>ee instructio</u>		o your hospital	0.00	62. 01
63. 00	Has your facility trained reside "Y" for yes or "N" for no in col						N	63. 00
	TOT YES OF WITCH HE THE COL	umir r. rr yes, compre	20 11110	.s or through	Unwei ghted	Unwei ghted	Ratio (col. 1/	
					FTEs Nonprovider Site	·	(col. 1 + col. 2))	
					1.00	2.00	3.00	
	Soction EEOA of the ACA Base Ver	ur ETE Docidonto in Ma	nnrovis	lor Sottings		ric vour cost -	conorting	
	Section 5504 of the ACA Base Year period that begins on or after					r is your cost r	eporti ng	
64. 00	period that begins on or after .	luly 1, 2009 and before yes, or your facilitable of unweighted nor tations occurring in a number of unweighted	re June ty train n-primar all non d non-pr	30, 2010. led residents ly care ly provider limary care				64. 00
64. 00	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the nun resident FTEs attributable to ro settings. Enter in column 2 the	July 1, 2009 and before yes, or your facilitations occurring in a number of unweighted out the following the follo	re June Ty train The primar The all non The non-primar The column The instruction	ad, 2010. ded residents by care provider imary care a the ratio	This base yea	0.00	0. 000000	64. 00
64. 00	period that begins on or after of Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your period of the	July 1, 2009 and before yes, or your facilitaber of unweighted nor trations occurring in a number of unweighted ur hospital. Enter in	re June Ty train The primar The all non The non-primar The column The instruction	ad, 2010. ded residents y care provider imary care 3 the ratio	This base yea	Unweighted FTEs in		64. 00

Provider CCN: 15-0183 Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/19/2018 11:06 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 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) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.									
Physical Occupational Speech									
1.00 2.00 3.00									
N	N	N	N	109. 00					
			1.00						
Y" for yes or	"N" for no. If	yes,	N	110.00					
	CRNA fee sched Physical 1.00 N I Demonstration Y" for yes or	CRNA fee schedule? See 42 Physical	CRNA fee schedule? See 42 N Physical Occupational Speech 1.00 2.00 3.00	CRNA fee schedule? See 42					

Health Financial Systems MONROE HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0183 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/19/2018 11:06 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 OO Name: PRIME HEALTHCARE SERVICES INC. Contractor's Name: NORIDIAN Contractor's Number: 1001 141 00 142.00 Street: 3300 GUASTI ROAD 3RD FLOOR PO Box: 142.00 143.00 City: ONTARIO 91761 143. 00 State: Zip Code:

1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν 159. 00 Ν Ν Ν 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161. 00 CMHC Ν Ν N 161. 00 161. 10 CORF N Ν 161.10 Ν 1.00 Mul ti campus

165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Ν 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zip Code County CBSA Name State 0 1.00 2.00 3.00 4.00 5.00

166. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.

168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)

168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)

169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)

Beginning Ending
1.00 2.00

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)

1.00 2.00

1.00 2.00

1.00 2.00

1.00 2.00

171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

	Financial Systems MONROE HC AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0183	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S Part II Date/Time P 5/19/2018 1	-2 repared:	
		Descr	i pti on	Y/N	Y/N		
			0	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		_	N	N	20. 00	
		Y/N	Date	Y/N	Date		
		1. 00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)				
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense		sale mada duri	ng the cost		23. 00	
23.00	reporting period? If yes, see instructions.	due to apprais	sars made duri	ng the cost		23.00	
24. 00	Were new leases and/or amendments to existing leases entere lf yes, see instructions	porting period?		24. 00			
25. 00	Have there been new capitalized leases entered into during	the cost repor	rting period?	If yes, see		25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	e cost reporti	na period2 La	r ves see		26. 00	
	instructions.		0 .				
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportir	ng period? If	yes, submit		27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	reporting		28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	hand funds (De	eht Service Ro	eserve Fund)		29. 00	
	treated as a funded depreciation account? If yes, see instr	ŕ					
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	rity with new	debt? If yes,	see		30.00	
31. 00							
32 00	Purchased Services Have changes or new agreements occurred in patient care ser	vices furnish	ed through cor	ntractual		32. 00	
	arrangements with suppliers of services? If yes, see instru	ctions.	-				
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	lied pertainin	ng to competi	tive bidding? If		33.00	
24.00	Provi der-Based Physi ci ans				I		
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provider-bas	sed physicians?		34.00	
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the p	provi der-based		35. 00	
	physicians during the cost reporting period? If yes, see in	Structions.		Y/N	Date		
	Home Office Costs			1. 00	2. 00		
36 00	Home Office Costs 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		37. 00	
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	ice different	from that of	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			N		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00	
	instructions.						
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	held by the cost report preparer in columns 1, 2, and 3,	JEFF		BROWN		41.00	
42. 00		HOSPITAL MANAC	GEMENT SERVICE	ES		42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost	714 992-1525		JEFF. BROWN@HMS	OFFICE, COM	43.00	
. 5. 00	report preparer in columns 1 and 2, respectively.				oz. oom	15.50	

Heal th F	Financial Systems	10SPI	TAL			In Lie	u of Form (CMS-2	2552-10	
HOSPI TAI	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE		Provi der (CCN: 15-0183	Peri Fror To	od: n 01/01/2017 12/31/2017		Pre	pared:
				3	. 00					
C	Cost Report Preparer Contact Information									
	Enter the first name, last name and the tit		CE0							41.00
h	held by the cost report preparer in columns	s 1, 2, and 3,								
r	respecti vel y.									
42. 00 E	Enter the employer/company name of the cost	report								42.00
l p	oreparer.									
43. 00 E	Enter the telephone number and email addres	ss of the cost								43.00
r	report preparer in columns 1 and 2, respect	ti vel y.								

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared:

					''	J 12/31/2017	5/19/2018 11:	
							I/P Days / O/P	00 4
							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						0	6. 00
7.00	Total Adults and Peds. (exclude observation			24	8, 760	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 920	0. 00		8. 00
9.00	CORONARY CARE UNIT	32. 00		0	0	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	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			32	11, 680	0. 00		14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		0	0		0	16. 00
17. 00	SUBPROVIDER - IRF	41. 00		0	0		0	17. 00
18. 00	SUBPROVI DER			_	_			18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	_		0	19. 00
20.00	NURSING FACILITY	45. 00		0	0		0	20. 00
21. 00	OTHER LONG TERM CARE	46. 00		0	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
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days							33. 00 33. 01
33. UI	LTCH site neutral days and discharges						I	33.01

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: | 5/19/2018 | 11:06 am

						5/19/2018 11:	06 am
		I/P Days	6 / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	2, 197	68	3, 299			1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	0	517				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				6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 197	68	3, 299			7. 00
8. 00	INTENSIVE CARE UNIT	151	9	921			8. 00
9. 00	CORONARY CARE UNIT	0	0				9. 00
10.00	BURN INTENSIVE CARE UNIT	ol ol	0	Ö			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	l ö	0	Ö			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	Ĭ	Ü	Ĭ			12. 00
13. 00	NURSERY		0	0			13. 00
14. 00	Total (see instructions)	2, 348	77	4, 220	0.00	178. 01	
15. 00	CAH visits	0	0		0.00	.,	15. 00
16. 00	SUBPROVIDER - I PF	ol	0		0.00	0.00	
17. 00	SUBPROVIDER - IRF	ol	0	i o			
18. 00	SUBPROVI DER]	_	_			18. 00
19. 00	SKILLED NURSING FACILITY	ol	0	l c	0.00	0.00	
20. 00	NURSING FACILITY		0	l c			
21. 00	OTHER LONG TERM CARE			l c		l e	
22. 00	HOME HEALTH AGENCY	ol	0	l c	0.00	0.00	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	ol	0	l c	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)	ol	0	l c			24. 10
25.00	CMHC - CMHC	o	0	l c	0.00	0.00	25. 00
25. 10	CMHC - CORF	o	0	l c	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	o	0	C	0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	178. 01	27. 00
28.00	Observation Bed Days		0	C			28. 00
29.00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			l c			31. 00
32.00	Labor & delivery days (see instructions)	o	0	l c			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
22.00	outpatient days (see instructions)						22.00
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	0					33. 00 33. 01
55. 51	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	۱ ۹		I	T. Control of the Con	I	, 55. 51

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared:

					J 12/31/201/	5/19/2018 11:0	
		Full Time		Di sch	arges		
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	626	24	1, 204	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	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	626	24	1, 204	
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	1	0	0	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	0	0	0	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0. 00					20.00
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	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
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 QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						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)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.02	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days			0			33.00
33. UT	LTCH site neutral days and discharges			0			33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/

March Marc						To	12/31/2017	Date/Time Prep 5/19/2018 11:0	
Non-physician anesthetist Part								Average Hourly	
PART 1 - BACE DATA			Number	Reported					
### SALANET 1			1.00	0.00	A-6)	3)		,	
### ARAMES 1.00 Total salaries (see 200.00 10,564.298 0 10,564.298 370,262.00 28.53 1.00 10,564.298 370,262.00 28.53 1.00 10,564.298 370,262.00 28.53 1.00 10,564.298 370,262.00 28.53 1.00 10,564.298 370,262.00 28.53 1.00 10,564.298 370,262.00 28.53 1.00 10,564.298 370,262.00 28.53 1.00 10,564.298 370,262.00 2.00		PART II - WAGE DATA	1.00	2.00	3.00	4.00	5. 00	6.00	
2. Display Contract September Sept		SALARI ES							
Non-physic claim anestherist Part 0	1.00		200. 00	10, 564, 298	0	10, 564, 298	370, 262. 00	28. 53	1.00
Non-physic clam anestherit st Part	2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
4 00 Physician-Part A - Administrative	3. 00	7 7		0	0	0	0. 00	0. 00	3. 00
Administrative		В							
4.01 Physicians - Part A - Teaching 0 0 0 0.00 0.00 0.00 5.00	4.00			0	0	U	0.00	0.00	4.00
Physician-Part B Form		Physicians - Part A - Teaching		-	· -				
Non-physician-Part B For	5.00			0	0	0	0.00	0.00	5.00
Services	6.00	Non-physician-Part B for		0	0	0	0. 00	0. 00	6. 00
### approved program									
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00		21. 00	0	0	0	0.00	0. 00	7. 00
residents (in an approved programs)	7. 01			0	0	0	0. 00	0. 00	7. 01
Nome office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0		residents (in an approved							
Organization personnel Organization personnel Organization personnel Organization personnel Organization personnel Organization personnel Organization Orga	8. 00			0	0	0	0.00	0. 00	8. 00
10.00 Excluded area salaries (see 90,620 0 90,620 3,176.00 28.53 10.00		organization personnel							
Instructions OTHER WACES & RELATED COSTS			44.00	90, 620		-			
11.00 Contract labor: Direct Patient 0 0 0 0 0 0 0 0 0		instructions)		·		·	·		Į
12.00 Contract labor: Top level management and other management and other management and administrative services	11. 00			0	0	0	0.00	0.00	11. 00
management and other management and other management and administrative services	12.00			40.000		(0.000	475.00	127 22	12.00
Services	12.00			60, 000	0	60, 000	475.00	126. 32	12.00
13.00 Contract Labor: Physician-Part 0 0 0 0 0.00 0.00 13.00 14.00 Home office and/or related organization sal aries and wage-related costs 14.01 14.02 Related organization sal aries 674,574 0 674,574 25,485,00 26,47 14.01 14.01 Related organization sal aries 674,574 0 674,574 25,485,00 26,47 14.01 15.00 Home office sal aries 674,574 0 0 0 0 0 0 0 15.00 Home office and Contract 0 0 0 0 0 0 0 15.00 Home office and Contract 0 0 0 0 0 0 0 15.00 Related organization sal aries 0 0 0 0 0 0 15.00 Home office and Contract 0 0 0 0 0 0 15.00 Related organization 0 0 0 0 0 16.00 Related costs 0 0 0 0 0 17.00 Regerelated costs 0 0 0 0 18.00 Regerelated 0 0 0 0 18.00 Rel									
14.00 Home office and/or related or o o o o o o o o o o o o o o o o o o	13. 00			0	О	0	0.00	0. 00	13. 00
Orgal rozation sall ariles and wage-rel lated costs	14 00			0		0	0.00	0.00	14 00
14. 01 Home orffice salaries 674, 574 0 674, 574 25, 485. 00 26. 47 14. 01 14. 02 Related organization salaries 0 0 0 0 0 0 15. 00 Home orffice: Physician Part A 0 0 0 0 0 0 16. 00 Home orffice: Physician Part A 0 0 0 0 0 0 16. 00 Home orffice: Physician Part A 0 0 0 0 0 0 16. 00 Home orffice: Physician Part A 0 0 0 0 0 0 16. 00 Home orffice: Physician Part A 0 0 0 0 0 17. 00 Wage-related Costs (core) (see instructions) 0 0 0 0 18. 00 See instructions) 18. 00 18. 00 19. 00 Excluded areas 6, 149 0 6, 149 19. 00 19. 00 Non-physician anesthetist Part 0 0 0 0 20. 00 Non-physician anesthetist Part 8 0 0 0 22. 00 Physician Part A - Teaching 0 0 0 0 22. 00 Physician Part A - Teaching 0 0 0 0 23. 00 Physician Part B 0 0 0 0 24. 00 Wage-related Costs (RHC/FOHC) 0 0 0 0 25. 50 Home office: Physician Part A 0 0 0 0 25. 51 Related organization 0 0 0 0 25. 52 Home office: Physician Part A - Teaching 0 0 0 25. 52 Home office: Physician Part A 0 0 0 0 25. 53 Home office: Physician Part A 0 0 0 26. 00 Excluded Core) Home office wage-related (core) 0 0 0 26. 00 Teach Part A 0 0 0 27. 52 0 0 0 0 28. 53 0 0 0 0 29. 54 0 0 0 0 29. 55 0 0 0 0 29. 55 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 0 29. 50 0 0 29. 50 0 0 0 29. 50 0 0 29. 50 0 0 29. 50 0 29. 50 0 0 0 29. 50 0 29. 50 0 29. 50 0 29. 50 0 29. 50 0 29. 50 0 29. 50 0	14.00			O		U	0.00	0.00	14.00
14. 02 Rel ated organization salaries 0 0 0 0 0.00 0.00 14. 02 15. 00 Home offfice Physician Part A	1/ 01			674 574	_	674 574	25 495 00	26 47	14 01
- Admin istrativé Home office and Contract Home office Repaired Repai					Ö	074, 574			
16.00 Home office and Contract Physicians Part A - Teaching NAGE-RELATED COSTS 17.00 Wage-rel ated costs (core) (see instructions) 18.00 Wage-rel ated costs (other) (see instructions) 18.00 Wage-rel ated costs (other) (see instructions) 18.00 Wage-rel ated costs (other) (see instructions) 19.00 19	15. 00			0	0	0	0. 00	0.00	15. 00
WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see instructions) 17.00 wage-related costs (other) 0 0 0 0 0 0 18.00 wage-related costs (other) 0 0 0 0 0 0 0 0 0	16. 00			0	0	0	0.00	0. 00	16. 00
17.00 Wage-related costs (core) (see instructions) 17.00 18.00 Wage-related costs (other) 0 0 0 0 0 18.00 18.00 Wage-related costs (other) 0 0 0 0 0 18.00 19.00 Excluded areas 6,149 0 6,149 19.00 20.00									ł
18.00 Wage-related costs (other) (see instructions) 18.00 0 0 0 0 18.00	17. 00	Wage-related costs (core) (see		2, 514, 022	0	2, 514, 022			17. 00
19.00 Excluded areas 19.00 20.00 Non-physician anesthetist Part 19.00 20.00 Non-physician anesthetist Part 19.00 20.00 2	18 00			0	0	0			18 00
20. 00 Non-physician anesthetist Part 20. 00 21. 00 21. 00 21. 00 21. 00 21. 00 22. 00 22. 00 22. 00 22. 00 22. 00 23. 00 24. 00 24. 00 24. 00 25. 50 25. 51 Related organization wage-related (core) 25. 52 25. 53 25. 53 26. 00 25. 50 26. 00 27. 50 27. 53 26. 00 27. 50 27. 53 26. 00 27. 50		(see instructions)		_	_				
A				6, 149 0	0	6, 149 0			
B Physician Part A -		Α		, and the second	,				
Administrative Administrative Physician Part A - Teaching 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 01 Physician Part A - Teaching	22. 00			0	0	0			22. 00
23. 00	22. 01		-	0	0	О			22. 01
25. 00 Interns & residents (in an approved program) 25. 00 25. 50 Home office wage-related (core) 25. 51 Related organization 25. 52 Home office: Physician Part A 25. 52 Administrative - wage-related (core) 4. 00 0 0 0 0 0 0 0 0 0	23. 00	Physician Part B		0	0	0			23. 00
approved program Home office wage-related 0				0	0	0			
(core) Related organization wage-related (core) 455. 52 Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4. 00 162, 186 0 0 0 0 0 25. 51 0 25. 52 0 162, 186 0 162, 186 0 162, 186 0 162, 186 0 175 186 187 26. 00	25.00			O	٥				
25. 51 Related organization wage-related (core) Home office: Physician Part A	25. 50			0	0	0			25. 50
25. 52 Home office: Physician Part A	25. 51	Related organization		0	0	О			25. 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department	25 52	, ,		0	_	0			25 52
25. 53 Home office & Contract 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4. 00 162, 186 0 162, 186 3, 949. 00 41. 07 26. 00	20. JZ	- Administrative -		O	 				20. 02
Physicians Part A - Teaching -	25 53			Ω	_	n			25 53
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 162, 186 0 162, 186 3, 949. 00 41. 07 26. 00	20.00	Physicians Part A - Teaching -		O	 				25.55
26.00 Employee Benefits Department 4.00 162,186 0 162,186 3,949.00 41.07 26.00			<u> </u>						-
27. 00 Admi ni strati ve & General 5. 00 1, 488, 248 0 1, 488, 248 51, 574. 00 28. 86 27. 00		Employee Benefits Department	4. 00						
	27. 00	Administrative & General	5. 00	1, 488, 248	0	1, 488, 248	51, 574. 00	28. 86	27. 00

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/19/2018 11: 06 am

							5/19/2018 11:0	<u> 16 am</u>
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
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	0. 00	0.00	29.00
30.00	Operation of Plant	7. 00	290, 830	0	290, 830	11, 673. 00	24. 91	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	284, 441	0	284, 441	23, 227. 00	12. 25	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10.00	288, 557	0	288, 557	20, 080. 00	14. 37	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	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	953, 383	0	953, 383	13, 930. 00	68. 44	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	143, 689	0	143, 689	7, 998. 00	17. 97	41.00
	Records Library							
42.00	Soci al Servi ce	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

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION MONROE HOSPITAL Provider CCN: 15-0183

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2017 | Part III | To 12/31/2017 | Date/Time Prepared: | 5/19/2018 11: 06 am

instructions) 2.00 Excluded area salaries (see 90,620 0 90,620 3,176.00 28.53 2 instructions) 3.00 Subtotal salaries (line 1 10,473,678 0 10,473,678 367,086.00 28.53 3 minus line 2) 4.00 Subtotal other wages & related 734,574 0 734,574 25,960.00 28.30 4	
Col. 2 ± col. Salaries in col. 5 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 10,564,298 0 10,564,298 370,262.00 28.53 1 1.00 Excluded area salaries (see 90,620 0 90,620 3,176.00 28.53 2 1.00	
1.00 Net salaries (see instructions) 2.00 Excluded area salaries (see 90,620 0 90,620 3,176.00 28.53 2 instructions) 3.00 Subtotal salaries (line 1 10,473,678 0 10,473,678 367,086.00 28.53 3 minus line 2) 4.00 Subtotal other wages & related 734,574 0 734,574 25,960.00 28.30 4	
instructions) 2.00 Excluded area salaries (see 90,620 0 90,620 3,176.00 28.53 2 instructions) 3.00 Subtotal salaries (line 1 10,473,678 0 10,473,678 367,086.00 28.53 3 minus line 2) 4.00 Subtotal other wages & related 734,574 0 734,574 25,960.00 28.30 4	
2. 00 Excluded area salaries (see instructions) 90,620 0 90,620 3,176.00 28.53 2 3. 00 Subtotal salaries (line 1 minus line 2) 10,473,678 0 10,473,678 367,086.00 28.53 3 4. 00 Subtotal other wages & related 734,574 0 734,574 25,960.00 28.30 4	1.00
instructions) 3.00 Subtotal salaries (line 1	
3.00 Subtotal salaries (line 1 10,473,678 0 10,473,678 367,086.00 28.53 3 minus line 2) 4.00 Subtotal other wages & related 734,574 0 734,574 25,960.00 28.30 4	2.00
minus line 2) 4.00 Subtotal other wages & related 734, 574 0 734, 574 25, 960.00 28.30 4	
4.00 Subtotal other wages & related 734, 574 0 734, 574 25, 960.00 28.30 4	3.00
	4.00
costs (see inst.)	
5.00 Subtotal wage-related costs 2,514,022 0 2,514,022 0.00 24.00 5	5.00
(see inst.)	
6.00 Total (sum of lines 3 thru 5) 13,722,274 0 13,722,274 393,046.00 34.91 6	6.00
7.00 Total overhead cost (see 3,611,334 0 3,611,334 132,431.00 27.27 7	7.00
instructions)	

	To 12/31/2	2017 Date/Time Pro 5/19/2018 11:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	C	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	C	
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	C	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	C	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	C	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	C	
7.00	Employee Managed Care Program Administration Fees	C	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1, 738, 354	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	C	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	C	8. 02
8.03	Health Insurance (Purchased)	C	8. 03
9.00	Prescription Drug Plan	C	9. 00
10.00	Dental, Hearing and Vision Plan	C	
11. 00	Life Insurance (If employee is owner or beneficiary)	12, 395	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	C	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	C	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	C	14. 00
15. 00	'Workers' Compensation Insurance	2, 647	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	. C	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	C	
18. 00	Medicare Taxes - Employers Portion Only	C	
19. 00	Unempl oyment Insurance	C	
20.00	State or Federal Unemployment Taxes	760, 626	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see C	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	C	
23. 00		C	
24. 00	y '	2, 514, 022	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	l c	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 01/01/2017 Part V To 12/31/2017 Date/Time Prepared:

		To	o 12/31/2017	Date/Time Pre 5/19/2018 11:	
	Cost Center Description		Contract Labor		00 4
	<u> </u>		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, 514, 022	1. 00
2.00	Hospi tal		0	2, 514, 022	2. 00
3.00	Subprovi der - I PF		0	0	3. 00
4.00	Subprovi der - I RF		0	0	4. 00
5. 00	Subprovi der - (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
14. 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 Di al ysi s		0	0	17. 00
18. 00	Other		0	0	18. 00

Provider CON: 15-0183	Heal th	Financial Systems MONROE HOSP	eu of Form CMS-2	2552-10			
Uncompensated and Indigent care cost computation 1.00							
				1. 00			
Medicaid (see Instructions for each line) 2.00 Net revenue from Medicaid 2.001,017 2.00 Net revenue from Medicaid 3.00 Did you receive DSH or supplemental payments from Medicaid? 3.00 0.00 If line 3 is yes, does line 2 Include all DSH and/or supplemental payments from Medicaid? 4.00 5.00 0.00 Medicaid charges 2.012,132,436 6.00 7.00 Medicaid charges 1 lines line 6) 4.268,418 7.00 Medicaid charges 1 lines line 6) 4.268,418 7.00 Medicaid cost ((ine 1 lines line 6) 4.268,418 7.00 Medicaid cost ((ine 1 lines line 6) 4.268,418 7.00 7.00 Medicaid cost ((ine 1 lines line 6) 4.268,418 7.00 7.00 Medicaid cost ((ine 1 lines line 6) 4.268,418 7.00 7.00 Medicaid cost ((ine 1 lines line 6) 4.268,418 7.00 7.							
2.021,017 2.00 2.00 0.00 1 1 1 1 2 2.021,017 2.00 0.00 0.00 1 1 1 1 2 1 2 2.021,017 2.00 0.00 0.00 1 1 1 1 2 1 2 2 2 2	1.00		8)	0. 192858	1. 00		
1	2.00					2, 021, 017	2. 00
Medicaid charges		1	1 2		ıi d?		
Medical d cost (line 1 times line 6) Medical d cost (line 1 times line 6) Medical d program (line 7 minus sum of lines 2 and 5: if		1	from Medical	u			
Children's Healt Insurance Program (CHIP) (see instructions for each line) 9.00 Net revenue from stand-al one CHIP (charges 0.10.00 0.00							
Children's Health Insurance Program (CHIP) (see instructions for each line) 9,00 0,00	8.00		(line 7 minu	us sum of lir	es 2 and 5; if	2, 247, 401	8. 00
9.00 Net revenue from stand-alone CHIP 0,00 0			for each line	2)			
10.00 Stand-al one CHIP cost (line 1 times line 10) 0 10.00 0 11.0	9 00		TOT EACH TITLE	=)		0	9 00
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Not revenue from state or local indigent care program (see instructions for each line) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 13; if < zero then enter zero) Grants, donations and total unreinbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreinbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 2, 247, 401 19.00 2.00 3.00 18.00 Government grants, appropriations or transfers for support of hospital operations 10.00 Charity care charges and uninsured discounts for the entire facility facility aprients patients patients + col. 2) 10.00 Cost of patients approved for charity care and uninsured discounts (see 11,829 109,837 171,170 20.00 charity care charges and uninsured discounts for the entire facility of charity care charges and uninsured discounts for the entire facility of charity care (line 21 minus line 22) 0 98,854 98,854 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 17.00 Medicare landwale bad debts for the entire hospital complex (see instructions) 0 27.00 Medicare landward and control incomplex (see instructions) 0 27.01 Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5 514,269 30.00 Cos							
enter zero							
Other state or local government indigent care program (see instructions for each Line) 13.00 13.	12. 00		(line 11 mir	nus line 9; i	f < zero then	0	12. 00
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Larges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 14.00 larges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 14.00 larges for patients covered under state or local indigent care program (Not included in lines 6 or 10, 14.00 larges for patients covered under state or local indigent care program (line 15 minus line 0 larges 10, 15.00 liference between net revenue and costs for state or local indigent care program (line 15 minus line 0 larges 13, if < zero then enter zero) 13. if < zero then enter zero) Grants, donations, or acid unrelmbursed cost for Medicald, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Covernment grants, appropriations or transfers for support of hospital operations 19.00 Intervent patients appropriations or transfers for support of hospital operations 19.00 Intervent patients instructions) 20.00 Cost of patients approved for charity care and uninsured discounts (see linstructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see linstructions) 22.00 Payments received from patients for amounts previously written off as line patients p			structions fo	or each line)			
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16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 2, 247, 401 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 2, 247, 401 19.00 8, 12 and 16) 18.00 Uninsured patients patients 1 + + + + + + + + + + + + + + + + + +	15 00		14)			0	15 00
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17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Covernment grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 10. 0			HIP and state	e/local indig	ent care progran	ns (see	
Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Insured patients Hotal (col. 1 + col. 2)							
B, 12 and 16) Uninsured patients District District Patients District Distr					/	_	
Uniongensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 11, 829 109, 837 121, 666 21.00 instructions) 22.00 Payments received from patients for amounts previously written off as 12, 267 10, 983 23, 250 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 0 98, 854 98, 854 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit total bad debt expense for the entire hospital complex (see instructions) 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 514, 259 30.00	19.00		ai indigent (care programs	(Sull of Titles	2, 247, 401	19.00
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22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 21. 00 Payments received from patients of 10, 983 22. 00 Payments received from patients for amounts previously written off as 12, 267 10, 983 12, 267 10, 983 12, 267 10, 983 23, 250 22. 00 98, 854 23. 00 24. 00 24. 00 25. 00 27. 00 29. 153, 940 26. 00 27. 00 27. 00 28. 00 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29. 00 Cost of uncompensated care (line 23 column 3 plus line 29)	21. 00	Cost of patients approved for charity care and uninsured disc	ounts (see	11, 82	109, 837	121, 666	21. 00
23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 29.00 Stay limit (appendix limit) 24.00 24.00 25.00 25.00 25.00 25.00 25.00 26.00 27.00 2	22. 00	Payments received from patients for amounts previously writte	n off as	12, 26	10, 983	23, 250	22. 00
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26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 27.01 Non-Medicare bad debt expense (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 26.00 27.01 28.00 27.01 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 30.00		imposed on patients covered by Medicaid or other indigent car	•	0	25. 00		
27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 30.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 37.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 415,405 29.00 514,259 30.00	26 00		nstructions)		-	2, 153, 940	26, 00
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30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 514, 259 30.00		' '	vnonoo (os- !	motmuot ===\			
			xpense (see i	instructions)			
			line 30)				

	n Financial Systems	MONROE HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co		Peri od:	Worksheet A	
					From 01/01/2017 Fo 12/31/2017	Date/Time Pre	pared:
						5/19/2018 11:	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 867, 954	1, 867, 95	2, 677, 767	4, 545, 721	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		435, 926	435, 926	2. 00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	162, 186	2, 525, 523			2, 687, 709	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 488, 248	7, 891, 365			5, 878, 640	5. 00
7.00	00700 OPERATION OF PLANT	290, 830	286, 781	577, 61		1, 308, 303	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	284, 441	101 001		57, 637	57, 637	8. 00 9. 00
10.00	01000 DI ETARY	288, 557	191, 881 176, 703			424, 982 465, 260	10.00
11. 00	l i	200, 337	170, 709	403, 20	0	0	11.00
13. 00		953, 383	205, 412	1, 158, 79	-2, 075		13. 00
14. 00	l i	0	0		0	0	14. 00
15.00	01500 PHARMACY	0	0		0	0	15. 00
16. 00		143, 689	174, 985	318, 67	4 -18, 066	300, 608	16. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30.00		1, 287, 293	255, 386				30.00
31. 00 32. 00	1	678, 854	45, 133	723, 98	-4, 890	719, 097 0	31. 00 32. 00
33. 00			0			0	33.00
34. 00			0			Ö	34.00
40. 00		0	0		0	Ö	40.00
41. 00	1	0	0		0	0	41.00
43.00	04300 NURSERY	0	0		0	0	43.00
44. 00		0	0		0	0	44. 00
45. 00	l l	0	0		0	0	45. 00
46. 00		0	0		0	0	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	854, 914	077 550	1 022 47	3 -33, 954	1 700 F10	
50. 00 51. 00	I I	854, 914	977, 559	1, 832, 47	-33, 954	1, 798, 519	50. 00 51. 00
52. 00	I I		0			0	52.00
53. 00	1 1	0	0			Ö	53.00
54.00	1 1	734, 231	625, 631	1, 359, 86	-135, 480	1, 224, 382	54.00
55. 00	1 1	0	0		0	0	55. 00
56. 00		0	0		0	0	56. 00
57. 00	l i	0	0		0	0	57. 00
58. 00		0	0	1	0	0	58. 00
59.00		0 0 0 0 0 1	0	1 000 11	0	1 000 11/	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	856, 381	231, 735	1, 088, 11	0	1, 088, 116 0	60. 00 60. 01
61. 00	l l		0		0	0	61.00
62. 00		0	0		0	Ö	62.00
63.00		0	0		0	0	63. 00
64. 00		0	0		0	0	64. 00
65. 00		331, 773	37, 725			355, 784	65. 00
66. 00		101, 380	1, 330	102, 71	0	102, 710	66.00
67. 00	1	0	0		0	0	67.00
68. 00 69. 00		189, 856	24, 498	214, 35	1	0 214, 354	68. 00 69. 00
70. 00		107, 030	24, 470	214, 33	0	214, 334	70.00
71. 00		158, 075	2, 272, 399	2, 430, 47	-685, 397	1, 745, 077	71.00
72. 00	l l	0	0	,	685, 397	685, 397	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	324, 168	609, 931	934, 09	9 0	934, 099	73. 00
74. 00		0	0		0	0	74. 00
75. 00		0	0		0	0	75. 00
76. 98	1 1	224, 109	207, 678	431, 78	-122, 433	309, 354	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	U U	0) 0	0	77. 00
88. 00		l ol	0) 0	0	88. 00
89. 00	l i	0	0		0	Ö	89. 00
90. 00		o	0		0	0	90.00
91.00	09100 EMERGENCY	1, 121, 310	2, 045, 698	3, 167, 00	-3, 431	3, 163, 577	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS			1			
94. 00		0	0	1	0	0	94.00
95.00		0	0		0	0	95.00
96. 00 97. 00	1		0			0	96. 00 97. 00
98.00			0			0	98.00
99. 00			0			0	99.00
99. 10			0		ol ő	Ö	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		o o		100. 00
					·		

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 01/01/2017 To 12/31/2017	Date/Time Pre	parod:
				10 12/31/2017	5/19/2018 11:	
Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati		
•			+ col . 2)	ons (See A-6)	Trial Balance	
			,	, ,	(col. 3 +-	
					col. 4)	
	1.00	2.00	3. 00	4. 00	5. 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		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 ISLET ACQUISITION	0	0		0	0	111.00
113.00 11300 INTEREST EXPENSE		0		0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		0	0	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 through 117)	10, 473, 678	20, 655, 307	31, 128, 98	5 1, 908	31, 130, 893	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	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 CENTERSOT	0	0		0	0	194. 00
194.01 07951 PUBLIC RELATIONS	90, 620	12, 191	102, 81	1 -1, 908	100, 903	194. 01
194. 02 07952 MOB	o	0		0 0		194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	10, 564, 298	20, 667, 498	31, 231, 79	6 0	31, 231, 796	200. 00

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/19/2018 11:06 am

				5/19/2018 11:0)6 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-638	4, 545, 083		1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	3, 036	438, 962		2. 00
3.00	00300 OTHER CAP REL COSTS	0	1		3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-642, 602			5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-7, 434 0			7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG		1		9. 00
10. 00	01000 DI ETARY	-109, 022			10.00
11. 00	01100 CAFETERI A	0	0		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-84, 124	1, 072, 596		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1		14. 00
15. 00	01500 PHARMACY	0	O		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-212	300, 396		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-			
30.00	03000 ADULTS & PEDIATRICS	0			30.00
31.00	03100 I NTENSI VE CARE UNI T	0			31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT		-		32. 00 33. 00
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T		-		34. 00
40. 00	04000 SUBPROVI DER - I PF				40. 00
41. 00	04100 SUBPROVI DER – I RF		o o		41. 00
43. 00	04300 NURSERY	0	o		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	o		44. 00
45.00	04500 NURSING FACILITY	0	o		45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		46. 00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATING ROOM	-625, 718			50. 00
51.00	05100 RECOVERY ROOM	0			51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0			52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-6, 250	1, 218, 132		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	-0, 250			55. 00
56. 00	05600 RADI OI SOTOPE				56. 00
57. 00	05700 CT SCAN		Ö		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	o		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	o		59. 00
60.00	06000 LABORATORY	-1, 300	1, 086, 816		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	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	-		64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		1		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		1		67. 00
68. 00	06800 SPEECH PATHOLOGY		1		68. 00
	06900 ELECTROCARDI OLOGY	-4, 350			69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	1		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 745, 077		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			73. 00
74.00	07400 RENAL DIALYSIS	0	-		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	1		75. 00
76. 98	07700 ALLOCENELC STEM CELL ACQUISITION	0			76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		77. 00
88. 00	08800 RURAL HEALTH CLINIC		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00	09000 CLI NI C		Ö		90.00
91. 00	09100 EMERGENCY	-1, 963, 434	1, 200, 143		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,		92.00
	OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00	09500 AMBULANCE SERVICES	0	0		95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	이		96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	이		97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
	09900 CMHC				99.00
	09910 CORF 10000 L&R SERVICES-NOT APPRVD PRGM	0	1		99. 10 100. 00
	10000 Tak Services-NOT APPROD PROM				100.00
.01.00	7.0.00 HONE HEREIT MOENOT		۱	ı	.51.50

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

| Period: | Worksheet A | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/19/2018 11:06 am

			5/19/2018 11:06 am
Cost Center Description	Adjustments	Net Expenses	
		For Allocation	
	6. 00	7. 00	
SPECIAL PURPOSE COST CENTERS			
105.00 10500 KIDNEY ACQUISITION	0	0	105. 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 ISLET ACQUISITION	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0	115. 00
116. 00 11600 HOSPI CE	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-3, 442, 048	27, 688, 845	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 CENTERSOT	0	0	194. 00
194. 01 07951 PUBLIC RELATIONS	0	100, 903	194. 01
194. 02 07952 MOB	0	O	194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	-3, 442, 048	27, 789, 748	200. 00

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

Peri od: Worksheet A-6
From 01/01/2017
To 12/31/2017 Date/Time Prepared: 5/19/2018 11:06 am 5/19/2018 11:06

						5/19/2018 11:06 am	
		Increases					
	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	322, 485		1. 00)
2.00		0.00	0	0		2. 00)
3.00		0.00	0	0		3.00)
	TOTALS		0	322, 485			
	B - RENT AND LEASE - EQUIPMENT	T					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	209, 392		1. 00)
2.00		0.00	0	0		2. 00)
3.00		0.00	o	0		3.00)
4.00		0.00	o	0		4. 00)
5.00		0.00	O	0		5. 00)
6.00		0.00	O	0		6. 00)
7.00		0.00	O	0		7. 00)
8.00		0.00	O	0		8.00)
9.00		0.00	O	0		9.00)
	TOTALS			209, 392			
	C - UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	730, 692		1. 00)
2.00		0.00	0	0		2. 00)
3.00		0.00	0	0		3.00)
4.00		0.00	0	0		4. 00)
	TOTALS	— — T		730, 692			
	D - LAUNDRY EXPENSE						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	57, 637		1.00)
2.00		0.00	O	0		2.00)
	TOTALS						
	E - IMPLANTS AND PROSTHESIS						
1.00	IMPL. DEV. CHARGED TO	72.00	0	685, 397		1.00)
	PATI ENTS						
	TOTALS			685, 397			
	F - MORTGAGE INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 355, 282		1. 00)
	TOTALS	— — T		2, 355, 282			
	G - EQUIPMENT INTEREST	<u> </u>		<u>'</u>			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	226, 534		1.00)
	TOTALS			226, 534			
500.00	Grand Total: Increases		0	4, 587, 419		500. 00)
	•		'				

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

						10 12/31/2017	5/19/2018 11:06 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	ADMINISTRATIVE & GENERAL	5. 00	0	193, 968	10)	1. 00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	16, 860	0)	2. 00
3.00	WOUND CARE	76. 98	0	111, 657	0		3. 00
	TOTALS		0	322, 485			
	B - RENT AND LEASE - EQUIPMENT	Γ					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	910	10)	1. 00
2.00	ADULTS & PEDIATRICS	30.00	o	13, 758	0		2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	4, 890	0		3. 00
4.00	OPERATING ROOM	50.00	o	33, 954	. 0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	o	135, 480	0		5. 00
6.00	RESPI RATORY THERAPY	65.00	o	13, 714	. 0		6. 00
7.00	WOUND CARE	76. 98	o	1, 347	0		7. 00
8.00	EMERGENCY	91.00	o	3, 431	0		8. 00
9.00	PUBLIC RELATIONS	194. 01	O	1, 908	0		9. 00
	TOTALS	T		209, 392		1	
	C - UTILITIES	•					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	724, 279	0)	1. 00
2.00	NURSING ADMINISTRATION	13.00	O	2, 075	0		2. 00
3.00	MEDICAL RECORDS & LIBRARY	16.00	O	1, 206	0		3. 00
4.00	WOUND CARE	76. 98	O	3, 132	. 0		4. 00
	TOTALS			730, 692		1	
	D - LAUNDRY EXPENSE						
1.00	WOUND CARE	76. 98	0	6, 297	0)	1. 00
2.00	HOUSEKEEPI NG	9. 00	o	51, 340	0		2. 00
	TOTALS	T		57, 637		1	
	E - IMPLANTS AND PROSTHESIS	•					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	685, 397	0)	1. 00
	PATI ENTS						
	TOTALS	- $ -$		685, 397			
	F - MORTGAGE INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 355, 282	. 13		1. 00
	TOTALS			2, 355, 282		1	
	G - EQUIPMENT INTEREST	•	<u>'</u>				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	226, 534	. 11		1.00
	TOTALS			226, 534		1	
500.00	Grand Total: Decreases		0	4, 587, 419	1	1	500. 00
		'	-1		1		,

					То	12/31/2017	Date/Time Pre 5/19/2018 11:	pared: 06 am
				Acqui si ti ons	;			
		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							
1.00	Land	1, 300, 000	0		0	0	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	8, 116, 389	1, 421, 495		0	1, 421, 495	0	4. 00
5.00	Fi xed Equipment	6, 648, 766	1, 791, 234		0	1, 791, 234	0	5. 00
6.00	Movable Equipment	868, 084	39, 945		0	39, 945	0	6. 00
7.00	HIT designated Assets	0	0		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	16, 933, 239	3, 252, 674		0	3, 252, 674	0	8. 00
9.00	Reconciling Items	116, 389	0		0	0	0	9. 00
10.00	Total (line 8 minus line 9)	16, 816, 850	3, 252, 674		0	3, 252, 674	0	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	1, 300, 000	0					1. 00
2.00	Land Improvements	0	0					2. 00
3.00	Buildings and Fixtures	0	0					3. 00
4.00	Building Improvements	9, 537, 884	0					4. 00
5.00	Fi xed Equipment	8, 440, 000	0					5. 00
6.00	Movable Equipment	908, 029	0					6. 00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	20, 185, 913	0					8. 00
9.00	Reconciling Items	116, 389	o					9. 00
10.00	Total (line 8 minus line 9)	20, 069, 524	O					10. 00

Heal th	Financial Systems	MONROE HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0183	Peri od:	Worksheet A-7	,
					From 01/01/2017 To 12/31/2017		pared:
						5/19/2018 11:	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK		N 2, LINES 1 a	nd 2			
1. 00	CAP REL COSTS-BLDG & FLXT	1, 867, 954	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	1, 867, 954	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		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 & FLXT	0	1, 867, 954				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	1, 867, 954				3. 00

Health Financial Systems	MONROE HO	OSPI TAL		In Lieu of Form CMS-2552		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part III Date/Time Prep 5/19/2018 11:0	
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2. 00	3.00	4. 00	5. 00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	9, 506, 486 8, 440, 000 17, 946, 486	0	9, 506, 48 8, 440, 00 17, 946, 48	0 0. 470287 6 1. 000000	0 0 0	1. 00 2. 00 3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		•			
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 1, 874, 886 0 0	322, 485 209, 392 531, 877	1. 00
3.00 Total (sum of lines 1-2)	0	Sl	I JMMARY OF CAPI	0 1, 874, 886 TAL	531,877	3. 00
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		_	2 255 20		4 545 002	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	-7, 570 229, 570		_, -,,	0 0	4, 545, 083 438, 962	1. 00 2. 00
3.00 Total (sum of lines 1-2)	222, 000			-	4, 984, 045	

| Period: | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0183

				T	o 12/31/2017	Date/Time Prep 5/19/2018 11:0	
				Expense Classification on		371972018 11.	JO 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 & FIXT	4. 00 1. 00	5. 00 0	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2)		0	CAR DEL COCTO MADI E FOLLID	2.00		2 00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		Ü	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other (chapter 2)	В	-7, 570	CAP REL COSTS-BLDG & FIXT	1. 00	11	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of	1	0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		Ü		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter	А	-7, 434	OPERATION OF PLANT	7. 00	0	7. 00
8. 00	21) Tel evi si on and radio service (chapter 21)	A	-12, 840	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	-2, 713, 594			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	О	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-493, 160			0	12. 00
13.00	Laundry and linen service		0	DIETARY	0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-109, 022 0	DIETARY	10. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	pati ents						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-212	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		Ö		0. 00	Ö	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 00	Adjustment for occupational therapy costs in excess of	M-0-3	U	DOGGENTI UNAL THERAPT	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	Λ	SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	n-0-3	U	STEEDIT ATTIOLOGI	00.00		51.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	О	32. 00
33 UU	Depreciation and Interest RECRUITING	A	_60 170	ADMINISTRATIVE & GENERAL	5. 00		33. 00
	INCORDI ITINO	1 4 1	-07, 1/0	POWER A SENERAL	5.00	ા	

Health Financial Systems		MONROE HO	OSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0183	Peri od:	Worksheet A-8	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/19/2018 11:	
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
	D 1 (0 1 (0)					
Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
	1. 00	2.00	3. 00	4. 00	5. 00	
33. 01 CONTRI BUTI ONS	A	-3, 050	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02 OTHER REVENUE	В	-297	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03 LOBBYI NG	A	-2, 407	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33.04 OTHER ANCILLARY REVENUE	В	-23, 284	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
50.00 TOTAL (sum of lines 1 thru 49)		-3, 442, 048				50.00
(Transfer to Worksheet A,						
1 1 1 1 200 3	1				I	l

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

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.

OFFICE COSTS

				10 12/31/201/	5/19/2018 11:	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	RGANIZATIONS OR	CLAI MED	
		CAD DEL COCTO DI DO 6 FLYT	DUCL CAD COST DIDC	/ 022	0	1 00
1. 00	1		PHSI CAP COST-BLDG	6, 932	U	1. 00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	PHSI CAP INTEREST - BLDG	3, 036	0	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	PHSI CAP COST - EQUIP	17, 621	0	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	PHSI NON-CAPITAL OTHER	748, 311	0	4. 00
4.01	5. 00	ADMINISTRATIVE & GENERAL	PHSI NON-CAPITAL INTEREST	609	0	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1, 269, 669	4. 02
5.00	TOTALS (sum of lines 1-4).			776, 509	1, 269, 669	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

* 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 RELATED 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.

6. 00	В	0. 00 PRI ME HLTHCARE 100. 00	6. 00
7.00	В	0. 00 PRI ME HLTHCARE 100. 00	7. 00
8.00	В	0.00 PRIME HLTHCARE 100.00	8. 00
9.00	В	0.00 PRIME HLTHCARE 100.00	9. 00
10.00	В	0. 00 PRI ME HLTHCARE 100. 00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (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 organi zati on.
- 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 provi der

3.00

4.00

4.01

4 02

5.00

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

nas no	been posted to norksheet A,	cordinate transfer 2, the amount arrowable should be that cated the cordinate 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.

6. 00	HOME OFFICE	6.00	00
7.00	HOME OFFICE	7.00	00
8.00	HOME OFFICE	8.00	00
9.00	HOME OFFICE	9.00	00
10.00	HOME OFFICE	10.00	00
100.00		100.00	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.
- 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 organi zati on.
- 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 provi der

3.00

4.00

4.01

4 02 5.00 17, 621

609

0

0

0

748, 311

-493, 160

-1 269 669

Peri od: Worksheet A-8-2 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

				_				5/19/2018 11:	
	Wkst. A Line #	C	ost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			Identi fi er	Remuneration	Component	Component		ider Component	
					'	'		Hours	
	1. 00		2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	5. 00	DR. A		28, 418	28, 418	0	0		1. 00
2.00	13. 00	DR. B		123, 266	63, 266	60,000	171, 400	475	2. 00
3.00	50, 00			625, 718			0	0	3. 00
4. 00	54. 00			6, 250				o	4. 00
5. 00	60.00			1, 300				0	5. 00
6. 00	69. 00			4, 350				0	6. 00
7. 00	91.00			1, 963, 434				0	7. 00
8. 00	0.00	DIV. U		1, 703, 434	1, 703, 434	0		0	8. 00
9. 00	0.00				0	0		0	9. 00
10. 00	0.00				0	0		0	10. 00
	0.00			2 752 724	0 (00 70)	(0.000	0	_	200. 00
200.00	WI+ A I : //		+ C+ /Db	2, 752, 736					200.00
	Wkst. A Line #	C	ost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
			Identi fi er	Limit	Unadjusted RCE		Component	of Malpractice	
					Limit	Continuing	Share of col.	Insurance	
	1.00		2.00	0.00	0.00	Educati on	12	14.00	
1.00	1.00	DD 4	2. 00	8.00	9.00	12. 00	13.00	14.00	1 00
1.00		DR. A		0					1.00
2.00	13. 00			39, 142			,	1	2. 00
3.00	50.00			0	0	0	0	0	3. 00
4. 00	54. 00			0	0	0	0	0	4. 00
5. 00	60. 00			0	0	0	0	0	5. 00
6.00	69. 00			0	0	0	0	0	6. 00
7.00	91. 00	DR. G		0	0	0	0	0	7. 00
8.00	0.00			0	0	0	0	0	8. 00
9. 00	0.00			0	0	0	0	0	9. 00
10.00	0. 00			0	0	0	0	0	10. 00
200.00				39, 142			0	0	200.00
	Wkst. A Line #	C	ost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
			ldenti fi er	Component	Limit	Di sal I owance			
				Share of col.					
				14					
	1. 00		2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		DR. A		0		_	20,		1.00
2.00	13. 00	DR. B		0	39, 142	20, 858	84, 124		2.00
3.00	50.00	DR. C		0	0	0	625, 718		3. 00
4.00	54. 00	DR. D		0	0	0	6, 250		4. 00
5.00	60.00	DR. E		0	0	0	1, 300		5. 00
6.00	69.00	DR. F		0	0	0	4, 350		6. 00
7.00	91.00	DR. G		0	0	0	1, 963, 434		7. 00
8. 00	0.00			0	0	0	0		8. 00
9. 00	0.00			1 0	l 0	l o	1		9. 00
10. 00	0.00			1 0	l 0	l o	1		10. 00
200.00]			0	39, 142	20, 858	2, 713, 594		200. 00
200.00	1			1	1 37, 142	20,000	2,710,074	1	200.00

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

					To	12/31/2017	Date/Time Prep 5/19/2018 11:0	
				CAPI TAL REI	_ATED COSTS		37 1 77 2010 11.	oo aiii
		Cost Center Description	Net Expenses	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		cost center bescription	for Cost	DEDG & TTAT	WVDEL EQUIT	BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
			0	1. 00	2. 00	4. 00	4A	
1.00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	4, 545, 083	4, 545, 083				1. 00
2.00	1	CAP REL COSTS-BLDG & FIXT	4, 545, 063	4, 545, 065	438, 962			2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2, 687, 709		312	2, 691, 252		4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5, 236, 038 1, 300, 869			385, 040 75, 244	6, 640, 756 1, 520, 128	5. 00 7. 00
8.00	1	LAUNDRY & LINEN SERVICE	57, 637	23, 949		75, 244	83, 899	8. 00
9.00	00900	HOUSEKEEPI NG	424, 982	0	0	73, 591	498, 573	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	356, 238	199, 517	19, 269	74, 656	649, 680 0	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	1, 072, 596	51, 688	4, 992	246, 661	1, 375, 937	13. 00
14.00		CENTRAL SERVI CES & SUPPLY	0	117, 677		0	129, 042	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	300, 396	31, 918 9, 692		0 37, 176	35, 001 348, 200	15. 00 16. 00
10.00		TENT ROUTINE SERVICE COST CENTERS	300, 370	7, 072	700	07, 170	010, 200	10.00
30.00	1	ADULTS & PEDIATRICS	1, 528, 921	324, 215		333, 051	2, 217, 500	30.00
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	719, 097	211, 190 0	1	175, 634 0	1, 126, 318 0	31. 00 32. 00
33. 00	03300	BURN INTENSIVE CARE UNIT	0	0	0	o	Ö	33.00
34.00		SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00		SUBPROVI DER	0	0	0	0	0	40. 00 41. 00
43. 00	04300	NURSERY	0	0	0	0	0	43. 00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00 46. 00		NURSING FACILITY OTHER LONG TERM CARE	0	0		0	0	45. 00 46. 00
	ANCI L	LARY SERVICE COST CENTERS		-	-	-		
50.00		OPERATING ROOM RECOVERY ROOM	1, 172, 801	486, 042	46, 942	221, 185	1, 926, 970	50.00
51. 00 52. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51. 00 52. 00
53.00	05300	ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	1, 218, 132	348, 681	33, 675	189, 962	1, 790, 450 0	54. 00 55. 00
56. 00	1	RADI OLOGI - THERAPEUTI C	0	0	0	0	0	56. 00
57. 00		CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	0	0	0	0	58. 00 59. 00
60.00		LABORATORY	1, 086, 816	104, 712	10, 113	221, 565	1, 423, 206	60.00
60. 01		BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61. 00 62. 00
63. 00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	Ö	0	0	63. 00
64.00		I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	355, 784 102, 710		2, 525 0	85, 837 26, 229	470, 292 128, 939	65. 00 66. 00
67. 00		OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00	1	SPEECH PATHOLOGY	0	0	0	40, 120	0	68.00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	210, 004	0	0	49, 120 0	259, 124 0	69. 00 70. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 745, 077	0	0	40, 897	1, 785, 974	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	685, 397	0	0	02 940	685, 397	72.00
73. 00 74. 00		RENAL DIALYSIS	934, 099	0	0	83, 869 0	1, 017, 968 0	73. 00 74. 00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76. 98 77. 00	1	WOUND CARE ALLOGENEIC STEM CELL ACQUISITION	309, 354	198, 139 0		57, 982	584, 611 0	76. 98 77. 00
77.00		TIENT SERVICE COST CENTERS	0	0	<u> </u>		0	77.00
88. 00	08800	RURAL HEALTH CLINIC	0	0	1	0	0	88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0	0	0	0	0	89. 00 90. 00
91. 00		EMERGENCY	1, 200, 143	253, 014	24, 436	290, 108	1, 767, 701	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS		0	0	n	0	94. 00
95. 00	09500	AMBULANCE SERVICES		0	1	o	0	95.00
96.00		DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 98. 00		DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE COST CENTERS		0	0	0	0	97. 00 98. 00
99. 00			0	0	1	o	o	

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part I Provider CCN: 15-0183

			To	12/31/2017	Date/Time Prepared: 5/19/2018 11:06 am
		CAPI TAL REI	LATED COSTS		
Cook Cooks Doors at a	Nat Francisco	DIDC & FLVT	M/DLE FOLLID	EMDL OVEE	C
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal
	Allocation			DEPARTMENT	
	(from Wkst A			DELAKTIVIENT	
	col . 7)				
	0	1.00	2.00	4. 00	4A
99. 10 09910 CORF	0	0	0	0	0 99.10
100.00 10000 I&R SERVICES-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 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 110.00 11000 INTESTINAL ACQUISITION	0	0	0	U O	0 109. 00 0 110. 00
111. 00 11000 TNTESTINAL ACQUISITION	0	0	0	U O	0 110.00
113. 00 11300 NTEREST EXPENSE	١	U	U	٩	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	0	٥	0 115.00
116. 00 11600 HOSPI CE		0	0	o O	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	27, 688, 845	3, 451, 014	333, 297	2, 667, 807	26, 465, 666 118. 00
NONREI MBURSABLE COST CENTERS		97 19 17 9 1 1		=/ ==:/ ==:	==,,
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	0	886, 282	85, 597	0	971, 879 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	0	0	0 194. 00
194. 01 07951 PUBLI C RELATIONS	100, 903	1, 034		23, 445	125, 482 194. 01
194. 02 07952 MOB	0	206, 753	19, 968	0	226, 721 194. 02
200.00 Cross Foot Adjustments		_	_	_	0 200. 00
201.00 Negative Cost Centers	07.700.710	0	0	0 (04 353	0 201.00
202.00 TOTAL (sum lines 118 through 201)	27, 789, 748	4, 545, 083	438, 962	2, 691, 252	27, 789, 748 202. 00

Provider CCN: 15-0183

| Period: | Worksheet B | From 01/01/2017 | Part I | Date/Time Prepared: | 5/19/2018 | 11: 06 am

						5/19/2018 11:	
Cost C	enter 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	
	/I CE COST CENTERS						1 00
	L COSTS-BLDG & FIXT L COSTS-MVBLE EQUIP						1. 00 2. 00
	EE BENEFITS DEPARTMENT						4. 00
	STRATIVE & GENERAL	6, 640, 756					5. 00
	ION OF PLANT	477, 319	1, 997, 447				7. 00
	Y & LINEN SERVICE						8.00
9. 00 00900 HOUSEK		26, 344 156, 551	13, 744	123, 967	655, 124		9. 00
10. 00 01000 DI ETAR		203, 999	114, 497	0	37, 813	1, 005, 989	1
11. 00 01000 DI ETAR		203, 999	114, 497		37,013		1
	G ADMINISTRATION	422 042	29, 662		0.704	942, 968 0	
		432, 043			9, 796 22, 303		1
	L SERVICES & SUPPLY	40, 519 10, 990	67, 532		,	0	
			18, 317	0	6, 049	0	1
	L RECORDS & LIBRARY DUTINE SERVICE COST CENTERS	109, 334	5, 562		1, 837	0	16. 00
	& PEDIATRICS	696, 287	186, 058	96, 927	61, 446	0	30.00
	IVE CARE UNIT	353, 663	121, 196		40, 025	58, 916	
	RY CARE UNIT	353,003	121, 170	27,000	40, 025	0	1
	NTENSIVE CARE UNIT		0		0	0	
	AL INTENSIVE CARE UNIT		0		0	0	
40. 00 04000 SUBPRO		0	0	0	0	0	
41. 00 04100 SUBPRO			0		0	0	
43. 00 04300 NURSER			0		0	0	
	D NURSING FACILITY	0	0		0	0	1
45. 00 04500 NURSI N		0	0	0	0	0	
	LONG TERM CARE	0	0	0	0	0	
	RVI CE COST CENTERS	<u> </u>		0	<u> </u>	0	40.00
50. 00 05000 OPERAT		605, 067	278, 926	0	92, 116	0	50.00
51. 00 05100 RECOVE		000,007	270, 720	o o	72, 110	0	
	RY ROOM & LABOR ROOM	0	0	l o	0	0	
53. 00 05300 ANESTH		0	0	l o	0	0	
	OGY-DI AGNOSTI C	562, 200	200, 098	l o	66, 083	0	
	OGY-THERAPEUTI C	002,200	200, 070	l o	00, 000	0	1
56. 00 05600 RADI 0I		0	0	l o	0	0	
57. 00 05700 CT SCA		0	0	0	0	0	
	IC RESONANCE IMAGING (MRI)	0	0	l o	0	0	
	C CATHETERIZATION	0	0	l o	0	0	
60. 00 06000 LABORA		446, 885	60, 091	l o	19, 845	0	1
60. 01 06001 BL00D		140,000	00, 071	١	17, 043	0	
	INICAL LAB SERVICES-PRGM ONLY		O		ŏ		61.00
	BLOOD & PACKED RED BLOOD CELLS	0	0	1	0	0	1
	STORING, PROCESSING & TRANS.	0	0	0	0	0	1
	ENOUS THERAPY	0	0	o o	0	0	
	ATORY THERAPY	147, 671	15, 004	i o	4, 955	0	1
66. 00 06600 PHYSI C		40, 487	10, 001	o o	1, 700	0	
	TI ONAL THERAPY	10, 10,	0	o o	0	0	
68. 00 06800 SPEECH		0	0	l ő	0	0	1
69. 00 06900 ELECTR		81, 365	0	l ő	0	0	
1 1	OENCEPHALOGRAPHY	01,000	0	l ő	0	0	
	L SUPPLIES CHARGED TO PATIENTS	560, 794	0	0	0	0	
	DEV. CHARGED TO PATIENTS	215, 214	0	آ م	0	0	
	CHARGED TO PATIENTS	319, 641	0	ا م	0	0	
74. 00 07400 RENAL), o +1	0	١	o o	0	1
	ON-DISTINCT PART)		0	l 0	o o	0	1
76. 98 07698 WOUND	· · · · · · · · · · · · · · · · · · ·	183, 567	113, 706	0	37, 552	0	
	NEIC STEM CELL ACQUISITION	0	,	ا م	0// 002	0	
	SERVICE COST CENTERS	<u> </u>			5		1 00
	HEALTH CLINIC	0	0	0	0	0	88. 00
	LLY QUALIFIED HEALTH CENTER	0	0	ا م	0	0	
90. 00 09000 CLINIC		0	0	ا م	0	0	1
91. 00 09100 EMERGE		555, 056	145, 198	ا م	47, 952	4, 105	
	ATION BEDS (NON-DISTINCT PART)	000,000	110, 170	Ĭ	17, 702	1, 100	92.00
	IRSABLE COST CENTERS						/2.00
	ROGRAM DI ALYSI S	0	0	0	٥	0	94. 00
	NCE SERVICES		0	0	0	0	
	E MEDICAL EQUIP-RENTED	ا	0		0	0	
	E MEDICAL EQUIP-RENTED		0		0	0	1
	REIMBURSABLE COST CENTERS		0		0	0	
99. 00 09900 CMHC	NEIWOUNDADEL CODI CENTERO		0		0	0	
99. 00 09900 CMHC 99. 10 09910 CORF			0		٥	0	
	RVI CES-NOT APPRVD PRGM		0		٥		100.00
101. 00 10100 HOME H		0	0		٥		100.00
	POSE COST CENTERS	ı O	U	1 0	U	0	1101.00
105. 00 10500 KI DNEY		0	0	0	0	0	105. 00
103. 00 10300 KI DINE I	AUQUI SI ITUN	<u>ı</u> 0	0	1 0	ı 이		1100.00

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

					5/19/2018 11:06 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
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 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
116. 00 11600 HOSPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 224, 996	1, 369, 591	123, 987	447, 772	1, 005, 989 118. 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	305, 169	508, 613	0	167, 972	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	0	0	0 194. 00
194. 01 07951 PUBLIC RELATIONS	39, 401	593	0	196	0 194. 01
194. 02 07952 MOB	71, 190	118, 650	0	39, 184	0 194. 02
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 through 201)	6, 640, 756	1, 997, 447	123, 987	655, 124	1, 005, 989 202. 00

Provider CCN: 15-0183

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/19/2018	11:06 am

				12/31/2017	5/19/2018 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						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 10. 00 01000 DI ETARY						9. 00 10. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	942, 968					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	49, 630	1, 897, 068				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	0	259, 396			14. 00
15. 00 01500 PHARMACY	0	o	0	70, 357		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	33, 087	0	0	0	498, 020	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	198, 518	632, 356	0	0	20, 762	30.00
31. 00 03100 I NTENSI VE CARE UNIT	82, 716	0	0	0	7, 834	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0		0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	o	0	o	0	41. 00
43. 00 04300 NURSERY	0	0	0	O	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	o	0	44. 00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00 O4600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCI LLARY SERVI CE COST CENTERS		(00.05/			50.400	
50. 00 05000 0PERATI NG ROOM	90, 988	632, 356	0	0	52, 400	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	U O	0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	90, 988	0	0	0	96, 524	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	Ö	Ö	o	0,021	55. 00
56. 00 05600 RADI OI SOTOPE	0	o	0	Ö	0	56. 00
57.00 05700 CT SCAN	0	О	0	О	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	99, 260	0	0	0	76, 898	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0	61. 00 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	64. 00
65. 00 06500 RESPIRATORY THERAPY	33, 087	o o	Ö	o	20, 347	65. 00
66. 00 06600 PHYSI CAL THERAPY	8, 272	O	0	o	2, 200	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	o	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	16, 543	0	0	0	10, 079	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 087	0	177, 575	0	66, 108	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	33, 087	0	81, 821	70, 357	42, 757 18, 708	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	33,007	0	0	70, 337	10, 700	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	Ö	o	0	o	0	75. 00
76. 98 07698 WOUND CARE	0	0	0	o	4, 824	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	O	0	O	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
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	89. 00
90. 00 09000 CLI NI C	0	(00.05/	0	0	0	90.00
91. 00 09100 EMERGENCY	173, 705	632, 356	0	U	78, 579	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0	O	0	O	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	o o	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o	0	Ö	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o	0	o	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	o	0	o	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	o		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	이	0	101. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MONROE HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0183

					5/19/2018 11:06 am
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
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 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	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	0	0 115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	942, 968	1, 897, 068	259, 396	70, 357	498, 020 118. 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	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	0	0	0 194. 00
194. 01 07951 PUBLI C RELATI ONS	0	0	0	0	0 194. 01
194. 02 07952 MOB	0	0	0	0	0 194. 02
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	942, 968	1, 897, 068	259, 396	70, 357	498, 020 202. 00

MONROE HOSPITAL

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

					To 12/31/2017 Date/Time Pro 5/19/2018 11:	
	Cost Center Description	Subtotal	Intern &	Total	37 177 2010 111	00 4111
			Residents Cost			
			& Post Stepdown			
			Adjustments			
	CENEDAL CEDVICE COCT CENTEDO	24. 00	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT			1		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					5. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO 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					11. 00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	4, 109, 854				30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	1, 817, 728	l .	1, 817, 72	0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	Ö	1		0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0		0	40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0			0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY				0	44. 00
45.00	04500 NURSING FACILITY	0	0		0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 678, 823	8 0	3, 678, 82	ব	50.00
51. 00	05100 RECOVERY ROOM	0,070,023	I .		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	53. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 806, 343	0	2, 806, 34	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE				0	56. 00
57. 00	05700 CT SCAN	0	0		0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 2, 126, 185	1		0 5	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	2, 120, 103		2, 120, 10	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		0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0	63.00
65. 00	06500 RESPIRATORY THERAPY	691, 356		691, 35	6	64. 00 65. 00
	06600 PHYSI CAL THERAPY	179, 898	1	179, 89		66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0 247 111	0	247 11	0	68. 00 69. 00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	367, 111		367, 11	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 623, 538	s o	2, 623, 53	8	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 025, 189	l l	1, 025, 18		72. 00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 459, 761	0	1, 459, 76	1	73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)				0	75. 00
76. 98	07698 WOUND CARE	924, 260	o o	924, 26	o	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC			I	ol	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0	89. 00
	09000 CLINIC	0	o o		o	90.00
91. 00	09100 EMERGENCY	3, 404, 652	1		2	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DIALYSIS	0) 0		0	94. 00
	09500 AMBULANCE SERVICES	0	o o		0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	97. 00
98. 00 99. 00	O9850 OTHER REIMBURSABLE COST CENTERS O9900 CMHC		0		0	98. 00 99. 00
	09910 CORF		0		ŏ	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		o	100. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MONROE HOSPITAL In Lieu of Form CMS-2552-10

Period: Worksheet B From 01/01/2017 Part I Provider CCN: 15-0183

				rom 01/01/2017 o 12/31/2017	Date/Time Prepared:
Cook Cooker Books at the	Culatatal	1 = + = = = 0	T-4-1		5/19/2018 11:06 am
Cost Center Description	Subtotal	Intern & Residents Cost	Total		
		& Post			
		Stepdown			
		Adjustments			
	24.00	25. 00	26. 00		
101.00 10100 HOME HEALTH AGENCY	0	0	20.00)	101. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>				
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	C)	105. 00
106.00 10600 HEART ACQUISITION	O	o	C)	106. 00
107.00 10700 LIVER ACQUISITION	0	0	C		107. 00
108.00 10800 LUNG ACQUISITION	0	0	C)	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	C)	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	C)	110. 00
111.00 11100 ISLET ACQUISITION	0	0	C)	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	C)	115. 00
116. 00 11600 HOSPI CE	0	0	C)	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	25, 214, 698	0	25, 214, 698	3	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C)	190. 00
191. 00 19100 RESEARCH	0	0)	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 953, 633	0	1, 953, 633	3	192. 00
193. 00 19300 NONPALD WORKERS	0	0	C)	193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERSOT	0	0)	194. 00
194. 01 07951 PUBLIC RELATIONS	165, 672	0	165, 672		194. 01
194. 02 07952 MOB	455, 745	0	455, 745		194. 02
200.00 Cross Foot Adjustments	0	0	C)	200. 00
201.00 Negative Cost Centers	0 7 700 7 10	0	07 700 710		201. 00
202.00 TOTAL (sum lines 118 through 201)	27, 789, 748	O	27, 789, 748	5	202.00

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

Capital Related Costs Cost Center Description Directly Assigned New Assigned New Capital Related Costs Directly Assigned New BEN	V2018 11: C PLOYEE JEFITS JRTMENT	o um
Assi gned New BEN	IEFITS ARTMENT	
Assi gned New BEN	IEFITS ARTMENT	
Canital I NED		
Related Costs		
0 1.00 2.00 2A	. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 CAP REL COSTS-BLDG & FIXT		1. 00
2. 00 O0200 CAP REL COSTS-MVBLE EQUIP		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 3,231 312 3,543 5.00 00500 ADMINISTRATIVE & GENERAL 0 929,872 89,806 1,019,678	3, 543	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 0 929, 872 89, 806 1, 019, 678 7. 00 00700 OPERATION OF PLANT 0 131, 331 12, 684 144, 015	504 99	5. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 0 23, 949 2, 313 26, 262	0	8. 00
9. 00 00900 HOUSEKEEPI NG 0 0 0 0 0 10. 00 10. 00 10. 00 10. 00 199, 517 19, 269 218, 786	97 98	9. 00 10. 00
11. 00 01100 CAFETERI A 0 0 0 0	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 0 51, 688 4, 992 56, 680 14. 00 01400 051, 688 13. 00 01400 051, 688 13. 00 01400 051, 688 14. 00 01400 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051, 688 051,	325	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 0 117, 677 11, 365 129, 042 15. 00 01500 PHARMACY 0 31, 918 3, 083 35, 001	0	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 9, 692 936 10, 628	49	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 0 324, 215 31, 313 355, 528	439	30. 00
31. 00 03100 NTENSI VE CARE UNI T 0 211, 190 20, 397 231, 587	231	31. 00
32.00 03200 CORONARY CARE UNIT 0 0 0 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	34. 00
40. 00 04000 SUBPROVI DER - PF 0 0 0 0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	41. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY 0 0 0	o	44. 00
45. 00 04500 NURSI NG FACILITY 0 0 0 0 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0	0	45. 00 46. 00
ANCILLARY SERVICE COST CENTERS	U	46.00
50. 00 05000 OPERATI NG ROOM 0 486, 042 46, 942 532, 984	292	50.00
51. 00 05100 RECOVERY ROOM	0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY 0 0 0	0	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 348, 681 33, 675 382, 356 55. 00 05500 RADI 0LOGY-THERAPEUTI C 0 0 0	250 0	54. 00 55. 00
56. 00 05600 RADI 01 SOTOPE	0	56. 00
57. 00 05700 CT SCAN	0	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	58. 00 59. 00
60. 00 06000 LABORATORY 0 104, 712 10, 113 114, 825	292	60.00
60. 01 06001 BLOOD LABORATORY	0	60. 01 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0 113	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0	35	66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0	65	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54 0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0	111	73. 00
74. 00 07400 RENAL DI ALYSI S	0	74. 00 75. 00
76. 98 07698 WOUND CARE 0 198, 139 19, 136 217, 275	76	76. 98
77. 00 O7700 ALLOGENEI C STEM CELL ACQUI SI TI ON O O O	0	77. 00
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0	0	89. 00
90. 00 09000 CLI NI C 0 0 0 0 91. 00 0 0 0 0 0 0 0 0 0	0 382	90. 00 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	302	92. 00
OTHER REI MBURSABLE COST CENTERS		04.00
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0	0	94. 00 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0	0	97. 00 98. 00
99. 00 09900 CMHC 0 0 0 0	0	99. 00
99. 10 09910 CORF 0 0 0	0	99. 10

			To	12/31/2017 0 12/31/2017	Date/Time Pre	
		0481741 851	ATER COOTS		5/19/2018 11:	06 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
cost center bescription	Assigned New	DLDG & TTAT	WIVDLE EQUIT	Subtotal	BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs				DELAKTIMENT	
	0	1.00	2.00	2A	4. 00	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	o	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. 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 INTESTINAL ACQUISITION	o	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	o	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	o	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 451, 014	333, 297	3, 784, 311	3, 512	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	0	886, 282	85, 597	971, 879	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	0	0	0	194. 00
194. 01 07951 PUBLI C RELATIONS	0	1, 034	100	1, 134	31	194. 01
194. 02 07952 MOB	0	206, 753	19, 968	226, 721	0	194. 02
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	4, 545, 083	438, 962	4, 984, 045	3, 543	202. 00

Provider CCN: 15-0183

| Period: | Worksheet B | From 01/01/2017 | Part II | Date/Time Prepared: | 5/19/2018 | 11: 06 am

					0 12/31/2017	5/19/2018 11:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10. 00	
GENER	AL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
	ADMINISTRATIVE & GENERAL	1, 020, 182					5. 00
	OPERATION OF PLANT	73, 328	217, 442	2			7. 00
	LAUNDRY & LINEN SERVICE	4, 047	1, 496	31, 805			8. 00
	HOUSEKEEPI NG	24, 050	0	0	= -,		9. 00
	DIETARY	31, 339	12, 464	0	1, 394	264, 081	
	CAFETERI A	0	2 220	0	0	247, 537	
	NURSING ADMINISTRATION	66, 372	3, 229		361	0	1
	CENTRAL SERVICES & SUPPLY PHARMACY	6, 225 1, 688	7, 351 1, 994		822 223	0	
	MEDICAL RECORDS & LIBRARY	16, 796	605		68	0	1
	I ENT ROUTINE SERVICE COST CENTERS	10, 770	003	,	00	0	10.00
	ADULTS & PEDIATRICS	106, 966	20, 254	24, 864	2, 265	0	30.00
•	INTENSIVE CARE UNIT	54, 331	13, 193		1, 475	15, 466	
	CORONARY CARE UNIT	0	O	0	O	0	
33. 00 03300	BURN INTENSIVE CARE UNIT	0	0	0	o	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	0	0	40. 00
1	SUBPROVIDER - IRF	0	0	0	0	0	
	NURSERY	0	0	0	0	0	1
•	SKILLED NURSING FACILITY	0	0	0	0	0	
	NURSING FACILITY	0	0	0	0	0	1
	OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0		0	0	0	46. 00
	OPERATING ROOM	92, 953	30, 364	. 0	3, 395	0	50.00
	RECOVERY ROOM	72, 753	30, 304	0	3, 373	0	
	DELIVERY ROOM & LABOR ROOM	l o			٥	0	1
	ANESTHESI OLOGY	0	Ö		Ö	0	
	RADI OLOGY-DI AGNOSTI C	86, 368	21, 783	o o	2, 436	0	
	RADI OLOGY-THERAPEUTI C	0	0	Ö	0	Ō	
56. 00 05600	RADI OI SOTOPE	0	O	0	o	0	56. 00
	CT SCAN	0	O	0	o	0	57. 00
58. 00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	o	0	58. 00
59. 00 05900	CARDI AC CATHETERI ZATI ON	0	0	0	o	0	59. 00
60.00 06000	LABORATORY	68, 653	6, 542	2 0	731	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
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	1
	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
	I NTRAVENOUS THERAPY	0	0	0	0	0	1
	RESPI RATORY THERAPY	22, 686	1, 633	0	183	0	
-	PHYSI CAL THERAPY	6, 220		0	0	0	
1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0			0	0	
-	ELECTROCARDI OLOGY	12, 500			0	0	
	ELECTROCARDI OLOGI	12, 500	0			0	
•	MEDICAL SUPPLIES CHARGED TO PATIENTS	86, 152			o o	0	
•	IMPL. DEV. CHARGED TO PATIENTS	33, 062	Ö		Ö	0	
	DRUGS CHARGED TO PATIENTS	49, 105	Ö	o o	ol	Ö	1
•	RENAL DIALYSIS	0		ol o	ol	0	
	ASC (NON-DISTINCT PART)	o	0	0	o	0	1
76. 98 07698	WOUND CARE	28, 200	12, 378	0	1, 384	0	76. 98
	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	0	0	-	0	
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
	CLINIC	0 0 0 0 7 0	45.00/	0	0	0	
	EMERGENCY	85, 270	15, 806	0	1, 767	1, 078	
	OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	REIMBURSABLE COST CENTERS			0	ما		04.00
	HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0				0	
•	DURABLE MEDICAL EQUIP-RENTED			, 0		0	
	DURABLE MEDICAL EQUIP-RENTED		0			0	1
	OTHER REIMBURSABLE COST CENTERS		0			0	
99. 00 09900			n		ام	0	1
99. 10 09910			o o	0		0	
-	I&R SERVICES-NOT APPRVD PRGM		O	o o	o		100.00
1	HOME HEALTH AGENCY	0		0	o		101. 00
	AL PURPOSE COST CENTERS						
105. 00 10500	KIDNEY ACQUISITION	0	0	0	0	0	105. 00

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

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

					5/19/2018 11:06 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
106. 00 10600 HEART ACQUISITION	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 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	956, 311	149, 092	31, 805	16, 504	264, 081 118. 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	46, 881	55, 369	0	6, 192	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	0	0	0 194. 00
194. 01 07951 PUBLIC RELATIONS	6, 053	65	0	7	0 194. 01
194. 02 07952 MOB	10, 937	12, 916	0	1, 444	0 194. 02
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 020, 182	217, 442	31, 805	24, 147	264, 081 202. 00

Provider CCN: 15-0183

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

			Ic	12/31/2017	Date/lime Pre 5/19/2018 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	•	ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS				<u>'</u>		
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 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
11. 00 01100 CAFETERI A	247, 537	400.005				11.00
13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	13, 028 0	139, 995	143, 440			13. 00 14. 00
15. 00 01500 PHARMACY		0	143, 440	38, 906		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	8, 686	O	0	0	36, 832	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	52, 111	46, 665	0	0	1, 537	30.00
31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	21, 714	0	0	O	580 0	31. 00 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT		0	0	0	0	33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	ا	o	0	o	0	34. 00
40. 00 04000 SUBPROVI DER - PF	o	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	o	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	44. 00
45. 00 04500 NURSI NG FACILITY 46. 00 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		40.00
50. 00 05000 OPERATING ROOM	23, 885	46, 665	0	0	3, 879	50.00
51.00 05100 RECOVERY ROOM	o	0	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	7 100	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	23, 885	0	0	0	7, 108 0	54. 00 55. 00
56. 00 05600 RADI OI SOTOPE	ا	o	0	o	0	56. 00
57. 00 05700 CT SCAN	ō	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	26, 057 0	0	0	0	5, 693	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	١	ď	U	o o	0	60. 01 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	ol	o	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	8, 686	0	0	0	1, 506	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2, 171 0	0	0	O	163 0	66.00
68. 00 06800 SPEECH PATHOLOGY		0	0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 343	o	0	0	746	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 686	0	98, 195	0	4, 894	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	45, 245	0	3, 166	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 74. 00 07400 RENAL DLALYSES	8, 686	O O	0	38, 906	1, 385 0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0	0	0	0	75. 00
76. 98 07698 WOUND CARE		o	0	o	357	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	O	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	45, 599	46, 665	0	0	0 5, 818	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	43, 377	40, 003	J		3, 010	92. 00
OTHER REIMBURSABLE COST CENTERS		1		1		
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES		o	0	O	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	97. 00 98. 00
98.00 09850 0THER REIMBURSABLE COST CENTERS		0	0	0	0	98. 00 99. 00
99. 10 09910 CORF		ol	0	ol	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	O	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	o	o	0	o	0	101. 00

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

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

			10	12/31/201/	5/19/2018 11:0	
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	
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	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	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	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		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	247, 537	139, 995	143, 440	38, 906	36, 832	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 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	0	0		194. 00
194. 01 07951 PUBLIC RELATIONS	0	0	0	0		194. 01
194. 02 07952 MOB	0	0	0	0		194. 02
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	247, 537	139, 995	143, 440	38, 906	36, 832	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MONROE HOSPITAL

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0183

						Date/Time Prepared: 5/19/2018 11:06 am
	Cost Center Description	Subtotal	Intern &	Total		67 177 20 10 11. 00 um
			Residents Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS					1.00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPING					9.00
10. 00	01000 DI ETARY					10. 00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
30. 00	O3000 ADULTS & PEDIATRICS	610, 629	O	610, 62	00	30.00
31. 00	03100 NTENSI VE CARE UNI T	345, 518		345, 51		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	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	О		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		0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		0	46. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	734, 417	O	734, 41	7	50.00
51. 00	05100 RECOVERY ROOM	734, 417	0	734, 4	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	О		0	52. 00
53.00	05300 ANESTHESI OLOGY	0 E24 104	0	E24 10	0	53. 00 54. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	524, 186 0	0	524, 18	0	55. 00
56. 00	05600 RADI OI SOTOPE	Ö	Ö		0	56. 00
57. 00	05700 CT SCAN	0	0		0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		0	58. 00 59. 00
60. 00	06000 LABORATORY	222, 793	O	222, 79		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o o	0		0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY	63, 478	0	63, 47		65. 00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	8, 589 0	0	8, 58	0	66.00
68. 00	06800 SPEECH PATHOLOGY	0	o		0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	17, 654	0	17, 65	54	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	197, 981	0	197, 98	31	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	81, 473	1	81, 47	' 3	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	98, 193	0	98, 19	0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0		0	75. 00
76. 98	07698 WOUND CARE	259, 670	O	259, 67		76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	O		0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89. 00
90.00	09000 CLINIC	0	0	470.00	0	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	479, 835	0	479, 83	55	91. 00 92. 00
,2.00	OTHER REIMBURSABLE COST CENTERS	ı	<u> </u>			721 00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0		0	94.00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	95. 00 96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	Ö	Ö		0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	O		0	98. 00
	09900 CMHC 09910 CORF	0	0		0	99. 00 99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0	100.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MONROE HOSPITAL

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part II Provider CCN: 15-0183

				Date/Time Prepared:
Cost Conton Description	Subtotal	Intern &	Total	5/19/2018 11:06 am
Cost Center Description		Residents Cost	iotai	
		& Post		
		Stepdown		
		Adjustments		
	24.00	25. 00	26. 00	
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	o	0	0	106. 00
107.00 10700 LIVER ACQUISITION	o	0	0	107. 00
108.00 10800 LUNG ACQUISITION	o	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	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	115. 00
116. 00 11600 HOSPI CE	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 3, 644, 416	0	3, 644, 416	118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 080, 321	0	1, 080, 321	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	0	194. 00
194. 01 07951 PUBLI C RELATI ONS	7, 290	0	7, 290	194. 01
194. 02 07952 MOB	252, 018	0	252, 018	194. 02
200.00 Cross Foot Adjustments	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 984, 045	0	4, 984, 045	202. 00

| Period: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0183

					o 12/31/2017	Date/Time Prep 5/19/2018 11:0	
		CAPITAL REI	LATED COSTS			37 197 2018 11.	JO alli
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	oost content beschiptron	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	neconci i i ati on	& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
	GENERAL SERVICE COST CENTERS	1.00	2.00	4. 00	5A	5. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT	105, 519					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		105, 519				2. 00
4. 00 5. 00	OO400	75 21, 588				21, 148, 992	4. 00 5. 00
7.00	00700 OPERATION OF PLANT	3, 049				1, 520, 128	7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	556	556 0		_	83, 899 498, 573	8. 00 9. 00
10.00	01000 DI ETARY	4, 632				649, 680	10. 00
11.00	01100 CAFETERI A	1 200	0	OE 2 202		1 275 027	11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	1, 200 2, 732				1, 375, 937 129, 042	13. 00 14. 00
15. 00	01500 PHARMACY	741	741	c		35, 001	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	225	225	143, 689	0	348, 200	16. 00
30.00	03000 ADULTS & PEDI ATRI CS	7, 527	7, 527			2, 217, 500	30. 00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	4, 903	4, 903 0	1		1, 126, 318 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		_	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF	0			_	0	40. 00 41. 00
43.00	04300 NURSERY	0	0	C	0	0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	o o				46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	11 204	11 204	054.014		1 00/ 070	F0 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	11, 284 0	11, 284 0	l			50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C		0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	8, 095	0 8, 095	734, 231	_	0 1, 790, 450	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0,070	0,070	701,201	Ö	0	55. 00
56. 00 57. 00	05600	0	0	C	0	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	o o		Ö	o o	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	057, 301	_	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2, 431 0	2, 431 0	856, 381 C		1, 423, 206 0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61. 00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	Ö	ő		Ö	ő	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	607	607 0			470, 292 128, 939	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	101, 380 C		120, 939	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	100.05	_	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY			189, 856 C	0	259, 124 0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	158, 075		1, 785, 974	71. 00
72. 00 73. 00	O7200 IMPL. DEV. CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS	0	0	324, 168	_	685, 397 1, 017, 968	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0	o o	324, 100 C		0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	224 100	_	0	75. 00
76. 98 77. 00	07698 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION	4, 600 0	4, 600 0	224, 109		584, 611 0	76. 98 77. 00
	OUTPATIENT SERVICE COST CENTERS	-			-		
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88. 00 89. 00
90.00	09000 CLINIC	0	Ö	C	Ö	Ö	90. 00
91.00	09100 EMERGENCY	5, 874	5, 874	1, 121, 310	0	1, 767, 701	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		<u> </u>			<u> </u>	92. 00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	·		1	94. 00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0 0	95. 00 96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		Ö	0	97. 00
98. 00	O9850 OTHER REIMBURSABLE COST CENTERS O9900 CMHC	0	0			0	98. 00 99. 00
77.00	Jo 7 700 J OWI TO	1 0	1 0	1	'I 0	١	77.00

			T	o 12/31/2017	Date/Time Prepared: 5/19/2018 11:06 am
	CAPI TAL REL	ATED COSTS	•		
Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL
			DEPARTMENT		(ACCUM. COST)
			(GROSS SALARI ES)		
	1. 00	2. 00	4. 00	5A	5. 00
99. 10 09910 CORF	0	0	0	0	0 99.10
100.00 10000 I&R SERVICES-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 ACQUISITION	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 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	80, 119	80, 119	10, 311, 492	-6, 640, 756	19, 824, 910 118. 00
NONREI MBURSABLE COST CENTERS		_	_	_1	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	20, 576	20, 576	0	0	971, 879 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0	00 (20	0	0 194.00
194. 01 07951 PUBLIC RELATIONS 194. 02 07952 MOB	24	24	90, 620	0	125, 482 194. 01
200.00 Cross Foot Adjustments	4, 800	4, 800	U	U	226, 721 194. 02 200. 00
201.00 Negative Cost Centers					200. 00
202.00 Regative cost centers 202.00 Cost to be allocated (per Wkst. B,	4, 545, 083	438, 962	2, 691, 252		6, 640, 756 202. 00
Part I)	4, 343, 063	430, 902	2, 091, 232		8, 840, 758 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	43. 073598	4. 160028	0. 258722		0. 313999 203. 00
204.00 Cost to be allocated (per Wkst. B,			3, 543		1, 020, 182 204. 00
Part II)			-,		.,
205.00 Unit cost multiplier (Wkst. B, Part			0.000341		0. 048238 205. 00
206.00 NAHE adjustment amount to be allocated					206. 00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,					207. 00
Parts III and IV)					l

Heal th	Financial Systems	MONROE H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2017 Fo 12/31/2017	Date/Time Pre	pared:
					1270172017	5/19/2018 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(FTE' S)	
		(SQUARE FEET)	LAUNDRY)				
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	80, 807					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	556					8. 00
9.00	00900 HOUSEKEEPI NG	0	0	80, 25°	1		9. 00
10.00	01000 DI ETARY	4, 632	0	4, 632			10.00
11. 00	01100 CAFETERI A	0	0	(,,	114	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	1, 200 2, 732		1, 200 2, 732		6	13. 00 14. 00
	01500 PHARMACY	741		74		0	15. 00
	01600 MEDI CAL RECORDS & LI BRARY	225		i		4	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	7, 527				24	
31. 00	03100 NTENSI VE CARE UNI T	4, 903	921	4, 903	.	10	
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0			0	32. 00 33. 00
	03400 SURGICAL INTENSIVE CARE UNIT					0	34.00
40. 00	04000 SUBPROVIDER - I PF	0	ا			0	40.00
	04100 SUBPROVI DER - I RF	0	0		o	0	41.00
43.00	04300 NURSERY	0	0		o	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	1	0	0	46. 00
50. 00	05000 OPERATING ROOM	11, 284	0	11, 28	1 0	11	50.00
51. 00	05100 RECOVERY ROOM	0	Ö	, 20	ol ol	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		o	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	8, 095	0	8, 09!	0	11	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			0	
56. 00 57. 00	05600	0	0			0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0			0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		o o	0	59. 00
60.00	06000 LABORATORY	2, 431	0	2, 43	0	12	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	62. 00 63. 00
	06400 I NTRAVENOUS THERAPY					0	64. 00
65. 00	06500 RESPIRATORY THERAPY	607	Ö	60	7 0	4	65. 00
	06600 PHYSI CAL THERAPY	0	0		o	1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0			2	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			4	70. 00 71. 00
72. 00		0	٥		ol ol	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		o	4	73. 00
	07400 RENAL DIALYSIS	0	0		o	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
76. 98	07698 WOUND CARE	4, 600		4, 600		0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	1	0	0	77. 00
88. 00		0	0		0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ō		o o	0	89. 00
90.00	09000 CLI NI C	0	0		o	0	90. 00
	09100 EMERGENCY	5, 874	0	5, 87	54	21	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
04.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	Ι ο	1 0	1 /	ol o	0	94. 00
	09500 AMBULANCE SERVICES	0	0			0	1
	09600 DURABLE MEDICAL EQUIP-RENTED	0	l ő		ol ől	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		ol ol	0	97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98. 00
	09900 CMHC	0	0			0	
	09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM					0	99. 10 100. 00
	10000 TAR SERVICES-NOT APPROD PROM	0	0				100.00
	1 1	<u>'</u>	<u>'</u>	<u>'</u>	<u>'</u>		

Health Financial Systems In Lieu of Form CMS-2552-10 MONROE HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0183 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/19/2018 11:06 am 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 10.00 9.00 11.00 8.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 106. 00 10600 HEART ACQUISITION 00000 0 106. 00 0 107. 00 10700 LIVER ACQUISITION 0 107 00 0 o 108.00 10800 LUNG ACQUISITION 0 108. 00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115, 00 0 \cap 0 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 55, 407 4, 220 54, 851 13, 233 114 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 20, 576 0 20, 576 0 193. 00 19300 NONPALD WORKERS 0 193.00 Ω 194.00 07950 OTHER NONREIMBURSABLE COST CENTERSOT 0 0 0 0 194. 00 194. 01 07951 PUBLIC RELATIONS 24 24 0 0 194. 01 194. 02 07952 MOB 0 194. 02 4,800 4,800 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 997, 447 123, 987 655, 124 1, 005, 989 942, 968 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 24. 718737 29. 380806 8, 271. 649123 203. 00 8. 163437 76. 021235 204.00 Cost to be allocated (per Wkst. B, 217, 442 31,805 24, 147 264, 081 247, 537 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0.300893 2, 171. 377193 205. 00 205.00 2. 690881 7.536730 19. 956246 II)

206.00

207. 00

206.00

207.00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

	Financial Systems	MONROE HO		N 45 0400		eu of Form CMS-2!	552-10
COST	ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0183	Peri od: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Prep	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/19/2018 11:0	6 am
	oust deficer beson per on	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT NURS.	(COSTED		(GROSS		
		HRS.) 13. 00	REQUI S.) 14. 00	15. 00	CHARGES) 16.00		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00		
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	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A	(240					11.00
14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	6, 240	2, 172, 914				13. 00 14. 00
15. 00	01500 PHARMACY	0	2, 1, 2, , 11	10	00		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 130, 742, 469		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	11	_1				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 080	0		0 5, 450, 752 0 2, 056, 777		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0		0 2,030,777		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	Ō		0 0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0		34.00
40.00	04000 SUBPROVI DER – I PF	0	0		0		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0		0		41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	ő		0 0		44. 00
45.00	04500 NURSING FACILITY	0	0		0 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	2, 080	ol	<u> </u>	0 13, 756, 856		50. 00
51. 00	05100 RECOVERY ROOM	2,080	0		0 13, 730, 630		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0		52.00
53. 00	05300 ANESTHESI OLOGY	0	0		0 0		53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 25, 335, 314		54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0				55. 00 56. 00
57. 00	05700 CT SCAN	0	o		0 0		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	O		0 0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0		59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0		0 20, 188, 485		60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		ď				61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	О		0 0		62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0		63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0 5 341 013		64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0 5, 341, 813 0 577, 708		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	o		0 0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	o		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 2, 646, 134		69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 1, 487, 517		0 17, 355, 737		70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		685, 397		0 11, 225, 364		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	10			73. 00
74. 00	07400 RENAL DIALYSIS	0	0		0 0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0		75. 00
76. 98 77. 00	07698 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 1, 266, 365		76. 98 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u>~</u>		<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	2, 080	0		0 20, 629, 709		90. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,000	o l		20, 027, 707		92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0		94.00
95.00	09500 AMBULANCE SERVICES	0	0		0		95.00
96. 00 97. 00	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD		0		0 0		96. 00 97. 00
	09850 OTHER REIMBURSABLE COST CENTERS		ol		o o		98. 00
99. 00	09900 CMHC	0	o		0 0		99. 00
	09910 CORF	0	0		0 0		99. 10
100.00	0 10000 1&R SERVICES-NOT APPRVD PRGM	0	Ol	l	0	1	100. 00

COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1
				From 01/01/2017 Fo 12/31/2017	Date/Time Prepared:
			'	10 12/31/2017	5/19/2018 11:06 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
	(SUPPLY	REQUI S.)	LIBRARY	
	(DI RECT NURS.	(COSTED		(GROSS	
	HRS.) 13. 00	REQUI S.) 14. 00	15. 00	CHARGES) 16.00	
101.00 10100 HOME HEALTH AGENCY	13.00	14.00			101. 00
SPECIAL PURPOSE COST CENTERS				<u> </u>	
105. 00 10500 KIDNEY ACQUISITION	0	0	(0	105. 00
106. 00 10600 HEART ACQUISITION	o	0		o	106. 00
107.00 10700 LIVER ACQUISITION	o	0	(0	107. 00
108.00 10800 LUNG ACQUISITION	o	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	111. 00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0	115. 00
116. 00 11600 HOSPI CE	0	0		0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 6, 240	2, 172, 914	100	130, 742, 469	118. 00
NONREI MBURSABLE COST CENTERS			1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	
191. 00 19100 RESEARCH	0	0	9	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	9	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0	193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERSOT	0	0		0	194. 00 194. 01
194. 01 07951 PUBLI C RELATI ONS 194. 02 07952 MOB	0	0			194. 01
200.00 Cross Foot Adjustments	٩	Ü		J U	200. 00
201.00 Negative Cost Centers					200.00
202.00 Cost to be allocated (per Wkst. B,	1, 897, 068	259, 396	70, 35	498, 020	
Part I)	1,077,000	237, 370	70, 33	470,020	202.00
203.00 Unit cost multiplier (Wkst. B, Part	304. 017308	0. 119377	703. 570000	0. 003809	203. 00
204.00 Cost to be allocated (per Wkst. B,	139, 995	143, 440	38, 906	36, 832	204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	22. 435096	0. 066013	389. 060000	0. 000282	205. 00
206.00 NAHE adjustment amount to be allocate	ed				206. 00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,					207. 00
Parts III and IV)	1		l		

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/19/2018 11:06 am Health Financial Systems

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

			'	0 12/31/2017	5/19/2018 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	Total costs	Di sal I owance	Total Costs	
	Part I, col.	,				
	26)					
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
30. 00 03000 ADULTS & PEDIATRICS	4, 109, 854		4, 109, 854	0	4, 109, 854	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 817, 728		1, 817, 728		1, 817, 728	31. 00
32.00 03200 CORONARY CARE UNIT	0		0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0		C	0	0	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0		0	0	0	34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	0			0	0	40. 00 41. 00
43. 00 04300 NURSERY	0		ĺ	0	ĺ	43.00
44.00 04400 SKILLED NURSING FACILITY	0		C	0	0	44. 00
45.00 04500 NURSING FACILITY	0		C	0	0	45. 00
46. 00 04600 OTHER LONG TERM CARE	0		C	0	0	46. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	3, 678, 823	I	3, 678, 823	0	3, 678, 823	50.00
51. 00 05100 RECOVERY ROOM	3,070,023		3, 070, 023		3, 070, 023	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	Ö	ł		0	Ö	52.00
53. 00 05300 ANESTHESI OLOGY	0		C	0	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 806, 343		2, 806, 343	0	2, 806, 343	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	55.00
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	0			0	0	56. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0	Ō	59. 00
60. 00 06000 LABORATORY	2, 126, 185		2, 126, 185	0	2, 126, 185	60.00
60. 01 06001 BLOOD LABORATORY	0		C	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		i c	0	Ō	64. 00
65. 00 06500 RESPI RATORY THERAPY	691, 356		691, 356		691, 356	65. 00
66. 00 06600 PHYSI CAL THERAPY	179, 898	1	179, 898	0	179, 898	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0 0	67. 00 68. 00
69. 00 06900 SELECTI FATHOLOGY	367, 111	0	367, 111	0	367, 111	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		C	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 623, 538		2, 623, 538		2, 623, 538	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 025, 189		1, 025, 189		1, 025, 189	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	1, 459, 761 0		1, 459, 761	0	1, 459, 761 0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0			0		75.00
76. 98 07698 WOUND CARE	924, 260		924, 260	0	924, 260	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		<u> </u>	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	1	I	1			00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		O C	0	0	88. 00 89. 00
90. 00 09000 CLI NI C	0			0	0	90.00
91. 00 09100 EMERGENCY	3, 404, 652		3, 404, 652	0	3, 404, 652	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0		<u> </u>		0	92.00
OTHER REIMBURSABLE COST CENTERS	1	ı	1	1		
94. 00 09400 HOME PROGRAM DI ALYSIS 95. 00 09500 AMBULANCE SERVICES	0		0	0	0	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			1	0		96.00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0			0	Ö	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		[c	0	0	98. 00
99. 00 09900 CMHC	0		C		0	99. 00
99. 10 09910 CORF 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM	0		0		0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	ł .	C			100. 00 101. 00
SPECIAL PURPOSE COST CENTERS						101.00
105.00 10500 KIDNEY ACQUISITION	0		C			105. 00
106. 00 10600 HEART ACQUISITION	0	ł	C		l e	106.00
107.00 10700 LIVER ACQUISITION	0		0			107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0				l	108. 00 109. 00
110.00 11000 NTESTINAL ACQUISITION	0				l	1109.00
111. 00 11100 SLET ACQUI SI TI ON	0				l	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 SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE	0					115. 00 116. 00
	1	I	1	<u>I</u>	<u> </u>	1.10.00

Health Financial Systems	MONROE H	MONROE HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2017	Worksheet C Part I		
				Γο 12/31/2017	Date/Time Pre 5/19/2018 11:		
		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		
200.00 Subtotal (see instructions)	25, 214, 698	3 0	25, 214, 69	3 0	25, 214, 698	200.00	
201.00 Less Observation Beds)	0	201. 00	
202.00 Total (see instructions)	25, 214, 698	3 o	25, 214, 69	3 o	25, 214, 698	202. 00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/19/2018 | 11:06 am Health Financial Systems

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

			Title	xVIII	Hospi tal	5/19/2018 11: PPS	<u>06 am</u>
			Charges		·	TEEDA	
	Cost Center Description	I npati ent	Outpati ent	lotal (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
				ŕ		Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00	03000 ADULTS & PEDI ATRI CS	5, 450, 752		5, 450, 752			30. 00
31.00	03100 INTENSIVE CARE UNIT	2, 056, 777		2, 056, 777			31. 00
32. 00	03200 CORONARY CARE UNIT	0		C			32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT	0					33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0					40. 00
41.00	04100 SUBPROVI DER - I RF	0		C			41. 00
43.00	04300 NURSERY	0		C			43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY						44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0		Č			46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	4, 961, 960	8, 794, 896 0	1	0. 267417 0. 000000	0. 000000 0. 000000	1
51.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0.00000	
53. 00	05300 ANESTHESI OLOGY	0	0	C	0. 000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 342, 044	22, 993, 270	25, 335, 314		0. 000000	1
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
57. 00	05700 CT SCAN	0	0		0. 000000	0.000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0. 000000	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	20, 100, 405	0.000000	0.000000	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 666, 741	16, 521, 744 0	20, 188, 485	0. 105317 0. 000000	0. 000000 0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONL	Y O	0	ď	0. 000000	0. 000000	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CEL	LS 0	0	C	0. 000000	0. 000000	1
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	C	0. 000000 0. 000000	0. 000000 0. 000000	
65. 00	06500 RESPIRATORY THERAPY	4, 225, 706	1, 116, 107	5, 341, 813		0.000000	
66. 00	06600 PHYSI CAL THERAPY	554, 717	22, 991			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	C	0. 000000	0.000000	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	716, 997	0 1, 929, 137	2, 646, 134	0. 000000 0. 138735	0. 000000 0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	710, 777	1, 727, 137	2,040,134	0. 000000	0. 000000	1
71. 00			9, 344, 579		0. 151163	l e	1
72. 00 73. 00		9, 084, 540	2, 140, 824			0.000000	
74.00		2, 602, 164	2, 309, 291 0	_	0. 297216 0. 000000	0. 000000 0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0. 000000	1
76. 98	07698 WOUND CARE	287	1, 266, 078			0.000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	C	0. 000000	0. 000000	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	С			88. 00
89. 00		0	0	C			89. 00
90. 00 91. 00		0 2, 006, 909	0 18, 622, 800	20, 629, 709	0. 000000 0. 165036		
92. 00			18, 022, 800			0.00000	
	OTHER REIMBURSABLE COST CENTERS	,					
94.00		0	0			0.000000	1
95. 00 96. 00	1	0	0		0. 000000 0. 000000	0. 000000 0. 000000	1
97. 00		O	0	-		0. 000000	
98. 00	1	0	0	C	0. 000000	0. 000000	1
99. 00 99. 10		0	0				99. 00 99. 10
	010000 I&R SERVICES-NOT APPRVD PRGM	0	0				100.00
	D 10100 HOME HEALTH AGENCY	0	0				101. 00
105 00	SPECIAL PURPOSE COST CENTERS 0 10500 KIDNEY ACQUISITION	0	0			I	105 00
	0 10600 HEART ACQUISITION	0	0	•			105. 00 106. 00
107.00	D 10700 LIVER ACQUISITION	O	Ö	1			107. 00
	0 10800 LUNG ACQUISITION	0	0	C			108. 00
	0 10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION	0	0				109. 00 110. 00
	0 11100 I SLET ACQUI SI TI ON		0				111.00
113.00	0 11300 INTEREST EXPENSE						113. 00
	0 11400 UTILIZATION REVIEW-SNF		^	_			114.00
	0 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 11600 HOSPICE	0	0				115. 00 116. 00
200.00	1	45, 680, 752	85, 061, 717	130, 742, 469			200. 00

Health Financial Systems	MONROE HO	MONROE HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C		
				From 01/01/2017	Part I		
			'	To 12/31/2017	Date/Time Pre		
					5/19/2018 11:	06 am	
		Title	: XVIII	Hospi tal	PPS		
		Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA		
			+ col. 7)	Ratio	I npati ent		
					Ratio		
	6.00	7. 00	8. 00	9. 00	10.00		
201.00 Less Observation Beds						201.00	
202.00 Total (see instructions)	45, 680, 752	85, 061, 717	130, 742, 46	9		202. 00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | Date/Time Prepared: | 5/19/2018 | 11:06 am | PDS

			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
	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	1				33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000 SUBPROVI DER – I PF				40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY				41. 00 43. 00
44. 00	1				44. 00
45. 00	04500 NURSING FACILITY				45. 00
46. 00	04600 OTHER LONG TERM CARE				46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS				.6. 55
50.00	05000 OPERATING ROOM	0. 267417			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	0.000000			53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 110768			54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0. 000000 0. 000000			55. 00 56. 00
57. 00	1 1	0. 000000			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60.00	06000 LABORATORY	0. 105317			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
64. 00	06400 I NTRAVENOUS THERAPY	0.000000			64. 00
65. 00 66. 00	06500 RESPIRATORY THERAPY	0. 129423			65. 00 66. 00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0. 311400 0. 000000			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 138735			69.00
70. 00	1	0. 000000			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 151163			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 091328			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 297216			73. 00
	07400 RENAL DIALYSIS	0. 000000			74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000			75. 00
76. 98	07698 WOUND CARE	0. 729853			76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0. 000000			77. 00
88. 00	08800 RURAL HEALTH CLINIC				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00		0. 000000			90. 00
91.00	09100 EMERGENCY	0. 165036			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
	OTHER REIMBURSABLE COST CENTERS				
94. 00	09400 HOME PROGRAM DI ALYSI S	0.000000			94.00
95.00		0. 000000 0. 000000			95. 00
96. 00 97. 00	1	0. 000000			96. 00 97. 00
98. 00	1	0. 000000			98.00
	09900 CMHC	0.00000			99.00
	09910 CORF				99. 10
	10000 &R SERVICES-NOT APPRVD PRGM				100. 00
101.00	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
	D 10500 KIDNEY ACQUISITION				105. 00
	10600 HEART ACQUISITION				106. 00
	10700 LIVER ACQUISITION				107. 00
	0 10800 LUNG ACQUISITION				108.00
	D 10900 PANCREAS ACQUISITION D 11000 INTESTINAL ACQUISITION				109. 00 110. 00
	DITION ISLET ACQUISITION				111.00
	11300 INTEREST EXPENSE				113. 00
	11400 UTILIZATION REVIEW-SNF				114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
	11600 HOSPI CE				116. 00
200.00					200. 00
201.00					201. 00
202.00	Total (see instructions)				202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/19/2018 | 11:06 am Health Financial Systems

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

Cost Center Description						5/19/2018 11:	06 am
Desir Center Description			Ti tl	e XIX		PPS	
NAME SET ADDITION SERVICE DOST CENTERS 1,00 2,00 3,00 4,00 5,00	Cost Center Description	(from Wkst. B,		Total Costs	RCE	Total Costs	
1.00							
MAY MAY BOUTH & SERVICE COST CENTERS 4, 109, 854			2.00	3.00	4. 00	5. 00	
31.00							
32.00							•
33.100	l l	1, 817, 728		1, 817, 728	0		•
34.00 03-000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 41.00 0 0 0 0 0 14.00 0 0 0 0 0 0 0 14.00 0 0 0 0 0 0 0 0 0		0			0		1
14.100 03-00 MURSERY 18FF 0 0 0 0 43.00 43		0		ĺ	0		
43.00 04300 MURSENT 0 0 0 0 43.00		0		0	0	0	40. 00
44.00 0.400 0.500 0.		0		0	0		1
45.00 04.500 MURSING FACILITY 0 0 0 0 45.00		0		0	0	_	
46.00 0.4000 OTHER LONG TERR CARE O O O 0.400		0			0	_	1
50.00		0		Ö	0	_	1
51.00 0.100 RECOVERY ROOM 0 0 0 0 51.00					1		
52.00							•
53.00 03800 AMESTHESI OLDOY 0 0 0 0 53.00		0			0		•
54.00 05400 RADIOLOY-DI ARMOSTIC 2.806,343 2.806,345 0 2.806,343 54.00 55.00 05500		0			0	_	
56.00 05000 RADIOI SOTOPE 0 0 0 0 55.00 0500 0500 075.00 07500		2, 806, 343		2, 806, 343	0	2, 806, 343	
57.00 05700 CT SCAM 0 0 0 0 0 0 57.00 0 0 0 58.00 05900 MAMERT IC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 05900 MAMERT IC RESONANCE IMAGING (MRI) 0 0 0 0 59.00 05900 CARDIAC CATHETRI ZATION 0 0 0 0 59.00 0 0 0 0 0 0 0 0 0		0		0	0		•
58. 00 0.5800 MAGNETIC RESONANCE I IMAGING (MRI) 0 0 0 55. 0.0 0.0		0		0	0		1
59,00 05900 CARDIAC CATHETERIZATION 0 0 0 59,00	l l	0			0	_	•
60.01 60.00 10.00 10.00 10.00 10.00 0 0 0 0 0 0 0 0 0		0		Ö	0	_	
61.00 06-100 PBPC ELINI CAL LAB SERVI CESPRIGN ONLY 0 0 0 0 0 0 0 0 0		2, 126, 185		2, 126, 185	0	2, 126, 185	60.00
62.00 06-200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0		0		0	0	_	
63.00 06-500 06-500 05-500 STORI NC, PROCESSI NC & TRANS. 0 0 0 0 64.00		0		0	0	_	
64.00		0			0	_	•
66.00 O6-600 PINST ICAL THERAPY 179, 898 0 179, 898 0 0 70, 898 60.00 0 0 0 0 0 0 0 0 0	· ·	0		Ö	0	-	1
67.00 06700 06700 06700 06700 06700 0 0 0 0 0 0 0 0 0							1
68. 00 06800 SPECCH PATHOLOGY 0 0 0 0 0 0 0 0 0		1		179, 898	0		1
69. 00 06900 ELECTROCARDIOLOGY 367, 111 367, 111 0 367, 111 0 0 0 0 0 0 0 0 0		0	0	0	0		
70. 00 07000 CLECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		367, 111	٥	367, 111	0	_	
17.2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,025, 189 1,025, 189 0 1,025, 189 72.00 73.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 073.00 075.00 077.00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0		1
1. 1. 1. 1. 1. 1. 1. 1.							1
74.00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00							1
75. 00 07500 ASC (NON-DISTINCT PART) 0 924, 260 924, 260 0 924, 260 0 924, 260 0 924, 260 0 924, 260 0 924, 260 0 924, 260 76. 98 07698 WOUND CARE 924, 260 0 924, 260 0 924, 260 0 924, 260 0 0 0 0 0 0 0 0 0				1, 439, 701	0		
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0		0		Ö	0		
Name				924, 260	0		
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEBERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 99. 00 90. 00 09900 CLINIC 0 0 0 0 0 0 99. 00 91. 00 09100 EMERGENCY 3, 404, 652 3, 404, 652 0 3, 404, 652 91. 00 92. 00 09200 DOBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 00 09500 ODBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 98. 00 09500 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 99. 00 09900 CMPIC 0 0 0 0 0 99. 00 99. 00 09900 CMPIC 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 101. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 105. 00 10500 KI DEVE ACQUI SITI ON 0 0 0 106. 00 107. 00 10700 LIVER ACQUI SITI ON 0 0 0 107. 00 108. 00 10800 LIVER ACQUI SITI ON 0 0 0 0 109. 00 110. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 110. 00 111. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 110. 00 111. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 110. 00 111. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 0 110. 00 111. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 0 0 111. 00 111. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 0 0 111. 00 111. 00 11100 INTESTI NEL ACQUI SITI ON 0 0 0 0 0 111. 00 111. 00 11100 INTESTI NEL ACQUI SITI ON 0 0 0 0 0 111. 00 111. 00 11100 INTESTI NEL ACQUI SITI ON 0 0 0 0 0 0 0 0 0] 0		0	0	0	77. 00
89, 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0		0			0	0	88 00
91. 00		Ö		Ö	0		1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00		-	l .	0	0		
OTHER REI MBURSABLE COST CENTERS O							
94. 00] 0				0	92.00
96. 00		0		0	0	0	94. 00
97. 00		0		0	0		
98. 00		0		0	0	_	
99. 00		0		0	0	_	
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM		0		ĺ	J		1
101. 00		0		0			
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 108.00 10800 LI VER ACQUI SI TI ON 0 0 0 107.00 108.00 10800 LI VER ACQUI SI TI ON 0 0 0 108.00 10800 LI VER ACQUI SI TI ON 0 0 0 108.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 107.00 109.00	l l	-	ł	0			
105. 00		0		0		0]101. 00
106. 00 10600 HEART ACQUI SI TI ON		0		1 0		0	105 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 ISTER ACQUISITION 0 0 0 111. 00 113. 00 11300 INTERST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00		0		Ö			
109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110. 00 11000 I NTESTINAL ACQUISITION 0 0 0 110. 00 111. 00 11100 I SLET ACQUISITION 0 0 0 111. 00 113. 00 11300 I NTEREST EXPENSE 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 1150 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00		0		0		0	107. 00
110. 00 11000 INTESTINAL ACQUISITION 0 0 1110. 00 1111. 00 1111. 00 11100 ISLET ACQUISITION 0 0 0 1111. 00 1131. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00		0		0			
111. 00 11100 1 SLET ACQUI SI TI ON		0					
113. 00 11300 I NTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115. 00							
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115. 00	113.00 11300 INTEREST EXPENSE						113. 00
1 0 1 0 0 1 0 0 1 0 0 0 0 0 0 0 0 0 0 0				0			
	110. 00/11000/11001102	1 0	I	1 0	1	0	1110.00

Health Financial Systems	MONROE H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/19/2018 11:	
		Titl	e XIX	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	
200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	25, 214, 698 0 25, 214, 698		25, 214, 69 25, 214, 69	o	25, 214, 698 0 25, 214, 698	201. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/19/2018 | 11:06 am Health Financial Systems

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

			Ti tl	e XIX	Hospi tal	5/19/2018 11: PPS	<u>06 am</u>
	Cook Contain December 1	I manadi and	Charges			TEEDA	
	Cost Center Description	I npati ent	Outpati ent	lotal (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
				ŕ		Rati o	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00	03000 ADULTS & PEDIATRICS	5, 450, 752		5, 450, 752	2		30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 056, 777		2, 056, 777			31.00
32. 00	03200 CORONARY CARE UNIT	0		()		32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0		(33. 00 34. 00
40. 00	04000 SUBPROVIDER - IPF	0)		40.00
41.00	04100 SUBPROVI DER - I RF	0)		41. 00
43.00	04300 NURSERY	0		(43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0				•	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0		Ċ			46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	4, 961, 960	8, 794, 896	_	0. 267417 0. 000000	0. 000000 0. 000000	
51.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0.00000	0.000000	
53. 00	05300 ANESTHESI OLOGY	0	0	d	0. 000000	0. 000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 342, 044	22, 993, 270	25, 335, 314		0.000000	
55. 00 56. 00	05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
57. 00	05700 CT SCAN	0	0		0. 000000	0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	C	0. 000000	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	20 100 405	0.000000	0.000000	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 666, 741	16, 521, 744 0	20, 188, 485	0. 105317 0. 000000	0. 000000 0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	O	0		0. 000000	0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0. 000000	0. 000000	1
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
65. 00	06500 RESPIRATORY THERAPY	4, 225, 706	1, 116, 107	5, 341, 813		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	554, 717	22, 991			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0.00000	0.000000	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	716, 997	1, 929, 137	2, 646, 134	0. 000000 0. 138735	0. 000000 0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	2, 010, 10	0. 000000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 011, 158	9, 344, 579			0. 000000	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	9, 084, 540 2, 602, 164	2, 140, 824 2, 309, 291			0. 000000 0. 000000	
74. 00		2,002,104	2, 307, 271	_	0.000000	0.00000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	1	0. 000000	0. 000000	
76. 98 77. 00	07698 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION	287	1, 266, 078			0.000000	
77.00	OUTPATIENT SERVICE COST CENTERS	j Uj	0		0. 000000	0. 000000	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0. 000000	0. 000000	88. 00
89. 00		0	0	(0.000000	
90. 00 91. 00		2, 006, 909	0 18, 622, 800	20, 629, 709	0. 000000 0. 165036	0. 000000 0. 000000	
92. 00	1	0	0 0 0 0 0 0			0. 000000	
	OTHER REIMBURSABLE COST CENTERS						
94. 00 95. 00		0	0		0. 000000 0. 000000	0. 000000 0. 000000	
96. 00	1 1	0	0		0.000000	0. 000000	
97. 00	1	0	0	C		0. 000000	
98. 00	1 1	0	0	(0. 000000	0. 000000	1
99. 00 99. 10		0	0)		99. 00 99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00	10100 HOME HEALTH AGENCY	0	0	()		101. 00
105.00	SPECIAL PURPOSE COST CENTERS 0 10500 KIDNEY ACQUISITION	0	0		1		105. 00
	10600 HEART ACQUISITION	0	0	•			106. 00
107.00	0 10700 LIVER ACQUISITION	0	0	(107. 00
	0 10800 LUNG ACQUISITION	0	0				108.00
	D 10900 PANCREAS ACQUISITION D 11000 INTESTINAL ACQUISITION		0				109. 00 110. 00
111.00	11100 ISLET ACQUISITION	0	0	Ì			111. 00
	0 11300 NTEREST EXPENSE						113.00
	D11400 UTILIZATION REVIEW-SNF D11500 AMBULATORY SURGICAL CENTER (D.P.)		0				114. 00 115. 00
	11600 HOSPI CE		0				116. 00
200.00	Subtotal (see instructions)	45, 680, 752	85, 061, 717	130, 742, 469			200. 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 01/01/2017	Part I	nanad.
				To 12/31/2017	Date/Time Pre 5/19/2018 11:	06 am
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	45, 680, 752	85, 061, 717	130, 742, 46	9		202. 00

| In Lieu of Form CMS-2552-10 | Worksheet C | Part | Part | Date/Time Prepared: 5/19/2018 11:06 am Peri od: From 01/01/2017 To 12/31/2017

		Title XIX	Hospi tal	PPS	50 diii
Cost Center Description	PPS Inpatient				
	Ratio				
INDATIENT DOUTINE SERVICE COST CENTERS	11.00				
30.00 O3000 ADULTS & PEDIATRICS					30. 00
31. 00 03100 I NTENSI VE CARE UNI T	1				31. 00
32. 00 03200 CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF					40. 00 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 OPERATI NG ROOM	0. 267417				50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 000000				51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 110768				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. 000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60. 00 06000 LABORATORY	0. 105317				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 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000 0. 000000				62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 129423				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 311400				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. 138735				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 151163				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 091328				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 297216				73.00
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000 0. 000000				74. 00 75. 00
76. 98 07698 WOUND CARE	0. 729853				76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
OUTPATIENT SERVICE COST CENTERS	2. 22222				
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. 165036				91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000				92. 00
94.00 OTHER REIMBURSABLE COST CENTERS 94.00 O9400 HOME PROGRAM DI ALYSI S	0. 000000				94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000				94. 00 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 105. 00 10500 KIDNEY ACQUISITION					105. 00
106. 00 10600 HEART ACQUISITION					105.00
107. 00 10700 LIVER ACQUISITION					108.00
108. 00 10800 LUNG ACQUISITION					107.00
109. 00 10900 PANCREAS ACQUISITION	1				100.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				•	110. 00
111. 00 11100 SLET ACQUISITION	1				111. 00
113.00 11300 INTEREST EXPENSE	1				113. 00
114.00 11400 UTILIZATION REVIEW-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 202.00 Total (see instructions)					201. 00 202. 00
202.00 Total (see instructions)					ZUZ. UU

Heal th Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 Provider CCN: 15-0183

			10	12/31/2017	5/19/2018 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	(WKST. B, Part		Net of Capital Cost (col. 1 -	Reduction	Reduction Amount	
	1, (01. 20)	11 (01. 20)	cost (cor. 1 -		Allourt	
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 678, 823	734, 417	2, 944, 406	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	C	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 806, 343	524, 186	2, 282, 157	0	0	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 800, 343	324, 100	2, 202, 137	0	0	55. 00
56. 00 05600 RADI 01 SOTOPE	0	d	o	0	0	56. 00
57.00 05700 CT SCAN	0	C	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0	0	0	59. 00
60. 00 06000 LABORATORY	2, 126, 185	222, 793	1, 903, 392	0	0	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	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.	0		o o	Ö	0	63. 00
64.00 06400 INTRAVENOUS THERAPY	0	C	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	691, 356			0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	179, 898	8, 589	171, 309	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	367, 111	17, 654	349, 457	0	0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	307, 111	17,054	349, 437	0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 623, 538	197, 981	2, 425, 557	Ö	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 025, 189	81, 473	943, 716	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 459, 761	98, 193	1, 361, 568	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	C	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 98 07698 WOUND CARE	924, 260	259, 670	664, 590	0	0	75. 00 76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	924, 200		004, 540	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	-		-			
88. 00 08800 RURAL HEALTH CLINIC	0	С	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89. 00
90. 00 09000 CLI NI C	0	470.025	0	0	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	3, 404, 652		2, 924, 817	0	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS			,	<u> </u>		72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	C	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		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			0	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	d	O	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	C	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0		0	0		105. 00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION	0		0	0		106. 00 107. 00
108. 00 10800 LUNG ACQUISITION	0			0		107.00
109. 00 10900 PANCREAS ACQUISITION	0		o o	Ö		109. 00
110.00 11000 INTESTINAL ACQUISITION	0		0	o	0	110. 00
111. 00 11100 SLET ACQUISITION	0	(0	0	0	111. 00
113. 00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	,		0	0	114. 00 115. 00
116. 00 11600 HOSPI CE	0			ol		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	19, 287, 116	2, 688, 269	16, 598, 847	o	0	200. 00
201.00 Less Observation Beds	0	C	0	o		201. 00
202.00 Total (line 200 minus line 201)	19, 287, 116	2, 688, 269	16, 598, 847	0	0	202. 00

Peri od: From 01/01/2017 To 12/31/2017

		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Cost Net of	Total Charges				
, , , , , , , , , , , , , , , , , , ,			Cost to Charge			
	Operating Cost	Part I. column	Ratio (col. 6			
	Reducti on	8)	/ col. 7)			
	6.00	7. 00	8.00			
ANCILLARY SERVICE COST CENTERS	<u>'</u>		<u> </u>			
50. 00 05000 OPERATI NG ROOM	3, 678, 823	13, 756, 856	0. 267417			50. 00
51.00 05100 RECOVERY ROOM	ol		0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0	C	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 806, 343	25, 335, 314				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0	Ċ	0. 000000			56. 00
57. 00 05700 CT SCAN	0	Ċ	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ċ	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	Č	0. 000000			59.00
60. 00 06000 LABORATORY	2, 126, 185	20, 188, 485				60.00
60. 01 06001 BLOOD LABORATORY	0	20, 100, 100	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	Č	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o o	Č	0. 000000			62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	o o	Č	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	691, 356	5, 341, 813				65. 00
66. 00 06600 PHYSI CAL THERAPY	179, 898	577, 708				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	177, 676	377, 700	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY			0.000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	2/7 111	2 (4(124	1			69.00
	367, 111	2, 646, 134				1
70. 00 07000 ELECTROENCEPHALOGRAPHY	2 (22 520	17 255 727	0.000000			70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 623, 538	17, 355, 737				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	1, 025, 189	11, 225, 364				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 459, 761	4, 911, 455				73. 00
74. 00 07400 RENAL DIALYSIS	0	C	0.000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		0.000000			75. 00
76. 98 07698 WOUND CARE	924, 260	1, 266, 365				76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.000000			77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.000000			89. 00
90. 00 09000 CLI NI C	0	C	0.00000			90.00
91. 00 09100 EMERGENCY	3, 404, 652	20, 629, 709				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	0.000000			92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSIS	0	C	0.000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0	C	0.000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0.000000			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	0.000000			97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	0.000000			98. 00
99. 00 09900 CMHC	0	C	0.000000			99. 00
99. 10 09910 CORF	0	C	0.000000			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	C	0.000000			100. 00
101.00 10100 HOME HEALTH AGENCY	0	C	0.000000			101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	C	0.000000			105. 00
106. 00 10600 HEART ACQUISITION	0	C	0.000000			106. 00
107. 00 10700 LIVER ACQUISITION	0	C	0.000000			107.00
108.00 10800 LUNG ACQUISITION	0	C	0.000000			108.00
109.00 10900 PANCREAS ACQUISITION	0	C	0. 000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	C	0. 000000			110.00
111.00 11100 ISLET ACQUISITION	0	C	0.000000			111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	0. 000000			115.00
116. 00 11600 HOSPI CE		C	0. 000000			116.00
200.00 Subtotal (sum of lines 50 thru 199)	19, 287, 116	123, 234, 940				200.00
201.00 Less Observation Beds	O	C				201. 00
202.00 Total (line 200 minus line 201)	19, 287, 116	123, 234, 940				202. 00
			. '			

Harlah Simonaial Contama	MONDOE LI	OCDI TAI		1 - 1:-	£ F CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	MONROE HO	Provider C		Period: From 01/01/2017 To 12/31/2017	w of Form CMS- Worksheet D Part I Date/Time Pre 5/19/2018 11:	epared:
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Related Cost (col. 1 - col 2)	Total Patient Days	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 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	610, 629 345, 518 0 0 0 0 0 0 0 956, 147 Inpatient Program days	C C	345, 51	8 921 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	185. 10 375. 16 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
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
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 through 199)	2, 197 151 0 0 0 0 0 0 0 0 0	406, 665 56, 649 0 0 0 0 0 0 0 0 0 0 463, 314				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 H	OSPI TAL		In Lie	eu 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 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod:
				10 12/31/2017	5/19/2018 11:	06 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		2.00	0.00		0.00	
50. 00 05000 OPERATI NG ROOM	734, 417	13, 756, 856	0. 05338	3, 257, 487	173, 904	50. 00
51.00 05100 RECOVERY ROOM	0	0	0. 00000	00	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000	00	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	524, 186	25, 335, 314	0. 02069		41, 719	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000		0	56. 00
57. 00 05700 CT SCAN	0	0	0. 00000		0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59. 00
60. 00 06000 LABORATORY	222, 793	20, 188, 485				60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0 00000	0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000 0. 00000		0	62. 00 63. 00
64. 00 06400 INTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	63, 478	5, 341, 813			1	65.00
66. 00 06600 PHYSI CAL THERAPY	8, 589				5, 291	
67. 00 06700 OCCUPATI ONAL THERAPY	0,307	· ·	0. 00000		0,271	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	17, 654	2, 646, 134			1	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	197, 981	17, 355, 737	0. 01140		50, 282	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	81, 473	11, 225, 364	0.00725		37, 831	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	98, 193	4, 911, 455	0. 01999	1, 710, 461	34, 197	73. 00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	00	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0	0	75. 00
76. 98 07698 WOUND CARE	259, 670				0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS		1				
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90. 00 09000 CLI NI C	470.025	0 (20 700	0.00000		0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	479, 835 0				25, 982 0	91. 00 92. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0	0.00000	0	0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	1 0	0	0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES			3.00000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	00	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000		ő	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	Ö	0. 00000		Ö	98. 00
200.00 Total (lines 50 through 199)	2, 688, 269	123, 234, 940		24, 323, 085	437, 684	

Health Financial Systems	MONROE H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C	CN: 15-0183 F	Peri od:	Worksheet D	
			Ę	rom 01/01/2017	Part III	
				o 12/31/2017	Date/Time Pre 5/19/2018 11:	parea:
		Ti +l c	xVIII	Hospi tal	PPS	oo alii
Cost Center Description	Nursing School			Allied Health	All Other	
oost center bescription	Post-Stepdown	livar string scribbin	Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	0		0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T					0	31. 00
32. 00 03200 CORONARY CARE UNIT		_	1	_	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT				_	0	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T		_		_	0	34.00
40. 00 04000 SUBPROVI DER - PF		_		_	0	40. 00
41. 00 04100 SUBPROVI DER - 1 FF					0	41.00
43. 00 04300 NURSERY					0	43.00
					U	
44. 00 04400 SKILLED NURSING FACILITY	C	_		0		44.00
45. 00 04500 NURSI NG FACI LI TY	C	0		0		45. 00
200.00 Total (lines 30 through 199)		0	() 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)		7.00	0.00	
LAUDATI ENT. DOUTLING OFFICE OFFICE	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1 0 000	0.00	0.407	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	C	_	-,		2, 197	30.00
31. 00 03100 INTENSI VE CARE UNIT		0	1		151	31. 00
32. 00 03200 CORONARY CARE UNIT		0	1		0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0	(0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	(0.00	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	C		(0	40. 00
41. 00 04100 SUBPROVI DER - I RF	C	0	(0	41. 00
43. 00 04300 NURSERY		0	(0	43. 00
44.00 04400 SKILLED NURSING FACILITY		0	(0	44. 00
45.00 04500 NURSING FACILITY		0	(0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	4, 220)	2, 348	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C					30. 00
31.00 03100 INTENSIVE CARE UNIT	C					31.00
32. 00 03200 CORONARY CARE UNIT	C					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	C					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	C					34.00
40. 00 04000 SUBPROVI DER - 1 PF	C					40.00
41. 00 04100 SUBPROVI DER - RF	C					41.00
43. 00 04300 NURSERY						43.00
44.00 04400 SKILLED NURSING FACILITY						44. 00
45. 00 04500 NURSI NG FACILITY						45. 00
200.00 Total (lines 30 through 199)						200. 00
	•	•				

Period: Worksheet D From 01/01/2017 Part IV To 12/31/2017 Date/Time Prepared: 5/19/2018 11:06 am THROUGH COSTS

						5/19/2018 11:0	06 am_
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	3001 30mtor 2000r ptron		Post-Stepdown	lui or ng concer	Post-Stepdown	/ · · · · · · · · · · · · · · · · · · ·	
			Adjustments		Adjustments		
		Cost		0.00		0.00	
	_	1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	C	0	(0	0	50.00
51.00	05100 RECOVERY ROOM		0	(0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	1	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY					Ö	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					0	54. 00
	I I					_	
55. 00	05500 RADI OLOGY-THERAPEUTI C		1	')	0	55. 00
56. 00	05600 RADI 01 SOTOPE		0	(0	0	56. 00
57.00	05700 CT SCAN	C	0	(0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0	(0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0	(0	0	59. 00
60.00	06000 LABORATORY		0	1	0	0	60.00
60. 01	06001 BLOOD LABORATORY					0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		1	1	,	٥	61. 00
	I I						
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			(_	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0	(1	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	C	0	(0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	C	0	(0	0	65.00
66. 00	06600 PHYSI CAL THERAPY		0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0	(0	ol	67. 00
68. 00	06800 SPEECH PATHOLOGY					0	68. 00
69. 00	06900 ELECTROCARDI OLOGY				ή	Ö	69. 00
70. 00	I I						
	07000 ELECTROENCEPHALOGRAPHY					0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1	(0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	() 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0	(0	0	73. 00
74.00	07400 RENAL DIALYSIS	C	0	(0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0	(0	0	75. 00
76. 98	07698 WOUND CARE		0		0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION			1		0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS		1	1	,	0	77.00
88. 00	08800 RURAL HEALTH CLINIC		0		0	0	00 00
				1	_	_	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1	(0	89. 00
90. 00	09000 CLI NI C	C	0	(0	0	90. 00
91. 00	09100 EMERGENCY	C	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C				0	92.00
	OTHER REIMBURSABLE COST CENTERS	*		•	*	•	
94.00	09400 HOME PROGRAM DI ALYSI S	C	0		0	0	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED				0	0	96.00
]			
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD		1	ή (٥	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	C) O	(0	98. 00
200.00	Total (lines 50 through 199)	[C	0	(0	0	200. 00

THROUGH COSTS

					10 12/31/2017	5/19/2018 11:	
			Ti tl e	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Social Control Code (p.t. on	Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost	•	Cost (sum of		(col . 5 ÷ col .	
			4)	col . 2, 3 and		7)	
			,	4)		_	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		13, 756, 856	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	C		0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	C		0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		25, 335, 314	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0	0.000000	55.00
56.00	05600 RADI OI SOTOPE	0	C		0	0.000000	56. 00
57.00	05700 CT SCAN	0	C		0	0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	Ċ		0	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ċ		0	0.000000	59. 00
60.00	06000 LABORATORY	0	Ċ		20, 188, 485		60.00
60. 01	06001 BLOOD LABORATORY	0	Ċ		0 0	0. 000000	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	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0. 000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0) 0	0. 000000	64. 00
65. 00	06500 RESPIRATORY THERAPY	0			5, 341, 813		65. 00
66. 00	06600 PHYSI CAL THERAPY	0			577, 708		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			0 377,700	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0				0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0			2, 646, 134		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			2,040,134	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			17, 355, 737		
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			17, 355, 737		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0					
	07400 RENAL DIALYSIS	0			4, 911, 455		
74. 00	1	0			٥	0.000000	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	1	0	0.000000	75. 00
76. 98 77. 00	07698 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION	0	(1	1, 266, 365 0		76. 98
77.00	OUTPATIENT SERVICE COST CENTERS	U		<u>'</u>	J 0	0.000000	77. 00
88. 00	08800 RURAL HEALTH CLINIC		C	\[\ \	0 0	0.00000	88. 00
	· · · · · · · · · · · · · · · · · · ·	0		1		0.000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(1		0.000000	89. 00
90.00	09000 CLI NI C	0	,	1		0.000000	90.00
91.00	09100 EMERGENCY	0	C		20, 629, 709		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	ή	0	0.000000	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DIALYSIS	0	C	\[\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0	0.000000	04.00
94. 00		0	(ή '	٥	0.000000	94.00
95.00	09500 AMBULANCE SERVICES			,		0.000000	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0	0.000000	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		(0	0.000000	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	('	0	0.000000	98. 00
200.00	Total (lines 50 through 199)	0	C	ין	123, 234, 940	1	200. 00

Health Financial Systems	MONROE HOSPITAL	MONROE HOSPITAL			
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Pro	ovider CCN: 15-0183	Peri od:	Worksheet D	

From 01/01/2017 Part IV To 12/31/2017 Date/Tim THROUGH COSTS Date/Time Prepared: 5/19/2018 11:06 am Title XVIII Hospi tal PPS Outpati ent I npati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col. 12) 13.00 x col. 10) 7) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 3, 257, 487 2, 309, 289 50.00 0 0 05100 RECOVERY ROOM 51.00 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0.000000 2, 016, 404 54.00 5, 354, 342 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 o 57.00 05700 CT SCAN 0.000000 0 57.00 Ω 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.000000 C 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 59.00 06000 LABORATORY 60.00 0.000000 2, 812, 680 0 1, 058, 836 0 60.00 06001 BLOOD LABORATORY 0.000000 60 01 60 01 |06100| PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63 00 O 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 2, 789, 126 194, 162 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 355, 865 281 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67 00 67 00 C 0 0 06800 SPEECH PATHOLOGY 0 68.00 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 643, 610 1, 230, 907 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 408, 035 0 0.000000 2, 510, 923 71 00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 5, 212, 350 541, 708 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1, 710, 461 0 1, 228, 028 0 73.00 73.00 07400 RENAL DIALYSIS 0.000000 0 74.00 74.00 0 07500 ASC (NON-DISTINCT PART) 0 75.00 75 00 0.000000 C 0 0 76. 98 07698 WOUND CARE 0.000000 0 0 0 0 76.98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 0 90.00 09000 CLI NI C 0.000000 0 90.00 09100 EMERGENCY 0 0.000000 91.00 91.00 1, 117, 067 3, 397, 823 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 0

0.000000

24, 323, 085

98.00 0

0 200. 00

17, 826, 299

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

200.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2017 | Part V |
| To 12/31/2017 | Date/Time Prepared: | 5/19/2018 | 11:06 am Health Financial Systems MONROE HAPPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0183

					10 12/01/201/	5/19/2018 11:	06 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge F	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00	0.00	(see inst.)	(see inst.)	F 00	
	ANGLILARY CERVICE COCT CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0.247417	2 200 200	Ι		(17 542	50.00
50. 00 51. 00		0. 267417 0. 000000	2, 309, 289		0 0	617, 543	51.00
52.00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	1
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 110768	5, 354, 342			593, 090	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0, 354, 342			0 373, 070	1
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0. 000000	0			0	
57. 00	05700 CT SCAN	0. 000000	0		0 0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	1
60.00	06000 LABORATORY	0. 105317	1, 058, 836		0 0	111, 513	1
60. 01	06001 BLOOD LABORATORY	0. 000000	0 0 0 0		0 0	0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	ŭ		0 0	Ĭ	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	Ō	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	Ō	1
65. 00	06500 RESPI RATORY THERAPY	0. 129423	194, 162		0	25, 129	1
66.00	06600 PHYSI CAL THERAPY	0. 311400	281		0	88	1
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 138735	1, 230, 907		0	170, 770	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 151163	2, 510, 923		0	379, 559	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 091328	541, 708		0 0	49, 473	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 297216	1, 228, 028	21	2 0	364, 990	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	
76. 98	07698 WOUND CARE	0. 729853	0		0	0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	_			0	
90.00	09000 CLINIC	0. 000000	0		0	0	90.00
91.00	09100 EMERGENCY	0. 165036	3, 397, 823		0	560, 763	
92. 00	09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92.00
04.00	OTHER REIMBURSABLE COST CENTERS	0.000000					04.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0. 000000			O		94. 00
95.00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0)) 0	_	95. 00 96. 00
96. 00 97. 00	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000 0. 000000	0	•	0 0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	1
200.00		0.000000	17, 826, 299		-	2, 872, 918	1
200.00			17,020,299		0 0	2,012,710	200.00
201.00	Only Charges						201.00
202.00			17, 826, 299	21	2 0	2, 872, 918	202, 00
	1.1.1. Shar goo (1.1.10 200 1.1.10 201)	1	, 020, 277		-1	2, 3, 2, 710	

Peri od: Worksheet D From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/19/2018 11:06 am Provider CCN: 15-0183

						5/19/2018 11:	06 am
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
	, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANOLLI ADV. CEDVI CE COCT CENTERS	6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS	1 _	_	ı			
50.00	05000 OPERATI NG ROOM	0					50. 00
51. 00	05100 RECOVERY ROOM	0	_				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00	05600 RADI 0I SOTOPE	0	0				56.00
57. 00	05700 CT SCAN	0	Ō				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0				59. 00
		0					1
60.00	06000 LABORATORY	0	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	1			62. 00
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	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Ö				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	63					73. 00
74.00		03					74.00
	07400 RENAL DIALYSIS	0	0				1
75. 00	07500 ASC (NON-DISTINCT PART)	0	_				75. 00
76. 98	07698 WOUND CARE	0	_				76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
	OUTPATIENT SERVICE COST CENTERS						4
88. 00	08800 RURAL HEALTH CLINIC	0					88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90.00	09000 CLI NI C	0	0				90.00
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0				94. 00
95.00	09500 AMBULANCE SERVICES	0					95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	1 0	0				96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		Ö	1			97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		0				98.00
200.00	1	42	_	1			200. 00
		63					1
201.00			1				201. 00
202 22	Only Charges		_				202 22
202.00	Net Charges (line 200 - line 201)	63	0				202. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	Health Financial Systems MONROE HOSP APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			In Lie Period: From 01/01/2017 To 12/31/2017	w of Form CMS- Worksheet D Part I Date/Time Pre 5/19/2018 11:	pared:
		Ti tl	e XIX	Hospital PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capi tal Related Cost (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT	610, 629 345, 518		610, 62 345, 51		185. 10 375. 16	
32. 00 CORONARY CARE UNIT	0 0		1	0 0	0.00	
33. 00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	1
40. 00 SUBPROVI DER - I PF	0	0	,	0 0	0.00	
41. 00 SUBPROVI DER – I RF	0	0		0 0	0.00	
43. 00 NURSERY	0		Ì	0 0	0.00	1
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
45. 00 NURSING FACILITY	0			0 0	0.00	1
200.00 Total (lines 30 through 199)	956, 147		956, 14	-		200. 00
Cost Center Description	Inpati ent	Inpati ent	700/ 1	., ., ., .,		200.00
5551 551151 F11511	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	68	12, 587				30.00
31.00 INTENSIVE CARE UNIT	9	3, 376	,			31.00
32. 00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	0	0)			41. 00
43. 00 NURSERY	0	0				43. 00
44.00 SKILLED NURSING FACILITY	0	0	1			44. 00
45.00 NURSING FACILITY	0	0	1			45. 00
200.00 Total (lines 30 through 199)	77	15, 963				200. 00

Health Financial Systems	MONROE HO	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0183	Period: Worksheet D		
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod:
				10 12/31/2017	5/19/2018 11:	06 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 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 OPERATING ROOM	734, 417	13, 756, 856	0. 05338	1, 021, 011	54, 508	50.00
51.00 05100 RECOVERY ROOM	0	0	0. 00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	00	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	524, 186	25, 335, 314	0. 02069		6, 206	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000		0	56. 00
57.00 05700 CT SCAN	0	0	0. 00000		0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
60. 00 06000 LABORATORY	222, 793	20, 188, 485			5, 325	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	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	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	63, 478	U F 241 012	0.00000		0	64. 00 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	8, 589	5, 341, 813 577, 708			4, 657 534	•
67. 00 06700 OCCUPATIONAL THERAPY	0, 369	377,708	0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	17, 654	2, 646, 134				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	17,001	2,010,101	0. 00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	197, 981	17, 355, 737	0. 01140			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	81, 473		0. 00725		9, 192	
73.00 07300 DRUGS CHARGED TO PATIENTS	98, 193				9, 220	
74.00 07400 RENAL DIALYSIS	0	0	0.00000		0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
76. 98 07698 WOUND CARE	259, 670	1, 266, 365	0. 20505	51 0	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	00	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	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	479, 835				5, 660	1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	0.00000	00 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	1 0	0	0.0000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	U	0. 00000	0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		_	0. 00000	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED			0.00000		0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0.00000		0	98.00
200.00 Total (lines 50 through 199)	2, 688, 269	123, 234, 940		5, 292, 007		1
	2,000,207	1 .20,20.,710	1	0,2,2,007	1 .5., 11,	,=30.00

Health Financial Systems	MONROE H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co	CN: 15-0183 F	Peri od:	Worksheet D	
			<u> </u>	From 01/01/2017	Part III	
				Γο 12/31/2017	Date/Time Pre 5/19/2018 11:	parea:
		Ti +I	e XIX	Hospi tal	PPS	oo alii
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
cost center bescription	Post-Stepdown	livar string scribbin	Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT				0	0	31. 00
32. 00 03200 CORONARY CARE UNIT		_		0	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			1		0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		_	1		0	34.00
40. 00 04000 SUBPROVI DER - PF		_	1		0	40. 00
41. 00 04100 SUBPROVI DER - 1 FF					0	41.00
43. 00 04300 NURSERY					0	43.00
	0	0			U	
44. 00 04400 SKILLED NURSING FACILITY	0	_				44.00
45. 00 04500 NURSI NG FACILITY	0	0		0		45. 00
200.00 Total (lines 30 through 199)	0	0	((0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)		7.00	0.00	
	4. 00	5.00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0.000	0.00		00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	_	-,		68	30.00
31. 00 03100 INTENSIVE CARE UNIT		0	•		9	31. 00
32. 00 03200 CORONARY CARE UNIT		0	1		0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	(0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	1	0.00	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0.00	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	(0.00	0	41. 00
43. 00 04300 NURSERY		0	(0	43. 00
44.00 04400 SKILLED NURSING FACILITY		0	(0.00	0	44. 00
45.00 04500 NURSING FACILITY		0		0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	4, 220		77	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0					40. 00
41. 00 04100 SUBPROVI DER - I RF	0					41. 00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
45.00 04500 NURSING FACILITY	0					45. 00
200.00 Total (lines 30 through 199)	0					200. 00
· · · · · · · · · · · · · · · · · · ·		•				-

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | 5/19/2018 11:06 am THROUGH COSTS

								5/19/2018 11:0	06 am_
					e XIX	<u></u>	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nur	sing School	Nursing Scho	ol	Allied Health	Allied Health	
		Anestheti st	Pos	st-Stepdown			Post-Stepdown		
		Cost	Ac	djustments			Adjustments		
		1.00		2A	2.00		3A	3.00	
	ANCILLARY SERVICE COST CENTERS	•			•				
50.00	05000 OPERATI NG ROOM			0		0	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			0		0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0		0	0	Ö	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C			0		0	0	0	55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C			0		0	0	0	56. 00
57. 00	05700 CT SCAN			0	()	0	0	0	57. 00
				0	()	- 1	0	,	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		1	U	<u>'</u>	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		2	U]	0	0	0	59. 00
60.00	06000 LABORATORY		2	0)	0	0	0	60. 00
60. 01	06001 BLOOD LABORATORY		7	O)	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)	O)	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	(0)	0	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	(C		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	68.00
69.00	06900 ELECTROCARDI OLOGY)	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY			0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS			0		0	0	0	73.00
74.00	07400 RENAL DI ALYSI S		ol	0	ol .	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)			0		0	0	0	75. 00
76. 98	07698 WOUND CARE			0		0	0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION			0		0	0	0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>		1		<u> </u>	Ü	77.00
88. 00	08800 RURAL HEALTH CLINIC			0)	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0		0	0	Ö	89. 00
90. 00	09000 CLINIC			0		0	0	0	90. 00
91. 00	09100 EMERGENCY			0		0	0	0	91. 00
				U	Ί	0	U	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		<u>/</u>			U		U	92.00
04.00	OTHER REIMBURSABLE COST CENTERS		,			0	0	0	04.00
94.00	09400 HOME PROGRAM DIALYSIS	C	1	0	'	0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	_		_			_	_	95. 00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		2	0	<u>'</u>	0	0	0	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	, c	2	0)	0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	2	O	P	0	0	0	98. 00
200.00	Total (lines 50 through 199)	[C)	0	P	0	0	0	200. 00

THROUGH COSTS

					10 12/31/201/	5/19/2018 11:	
			Ti tl	e XIX	Hospi tal	PPS	oo aiii
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost contor boson per on	Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost	•	Cost (sum of		(col. 5 ÷ col.	
			4)	col . 2, 3 and		7)	
			,	4)		_	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0 13, 756, 856	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	C		0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	C		0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 25, 335, 314	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	C		0	0.000000	56. 00
57.00	05700 CT SCAN	0	C		0	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0	0.000000	59. 00
60.00	06000 LABORATORY	0	C		0 20, 188, 485	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	C		0	0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		o o	0. 000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ċ		0	0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	Ċ		0	0.000000	1
65. 00	06500 RESPIRATORY THERAPY	0	Ċ		0 5, 341, 813		1
66. 00	06600 PHYSI CAL THERAPY	0	Č		0 577, 708		
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ċ		0	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	0	Č		0	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	Č		0 2, 646, 134		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Č		0 2,0.0,10.	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Č		0 17, 355, 737		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Č		0 11, 225, 364		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Č		0 4, 911, 455		
74. 00	07400 RENAL DIALYSIS	0			0 1, 711, 100	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	Č		0 0	0. 000000	
76. 98	07698 WOUND CARE	0	Č	1	0 1, 266, 365		1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	Č	1	0 1, 200, 000	0. 000000	
77.00	OUTPATIENT SERVICE COST CENTERS			′1	0 0	0.000000	77.00
88. 00	08800 RURAL HEALTH CLINIC	0	C)	ol o	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Č	1	0 0	0. 000000	1
90. 00	09000 CLINIC	0	Č	1	0	0. 000000	1
91. 00	09100 EMERGENCY	0	Č	1	0 20, 629, 709		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 20, 027, 707	0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS			1	0	0.000000	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	C		ol o	0.000000	94. 00
95. 00	09500 AMBULANCE SERVICES			1	٦	0.000000	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C			0. 000000	1
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED			3		0.000000	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			3		0.000000	1
200.00				3	0 123, 234, 940		200.00
200.00	Tiotal (Tilles 30 till ough 177)	1 9		Ί	0 123, 234, 740	I	1200.00

Health Financial Systems			MONROE HOSP	I TAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF I	NPATI ENT/OUTPATI ENT	ANCILLARY SERVI	CE OTHER PASS	Provider CCN: 15-0183	Peri od:	Worksheet D	

From 01/01/2017 To 12/31/2017 Part IV Date/Time Prepared: THROUGH COSTS 5/19/2018 11:06 am Title XIX Hospi tal PPS Outpati ent Outpati ent Cost Center Description Inpatient I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col. 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 1, 021, 011 0 0 50.00 0 05100 RECOVERY ROOM 51.00 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 299, 931 54.00 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 C 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 0 57.00 05700 CT SCAN 0.000000 57.00 Ω 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 C 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 06000 LABORATORY 0.000000 0 60.00 482, 534 0 60.00 06001 BLOOD LABORATORY 0 0.000000 60 01 60 01 |06100| PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63 00 0 63 00 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 391, 899 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.000000 35, 922 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67 00 0 Ω 67 00 Ω 06800 SPEECH PATHOLOGY 68.00 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 59, 886 0 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 029, 776 0.000000 0 71 00 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 1, 266, 531 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 461, 155 0 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 75 00 0.000000 Ω 0 0 76. 98 07698 WOUND CARE 0.000000 0 0 0 76.98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 ol 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 0 0 90.00 90.00 09000 CLI NI C 0.000000 0 0 09100 EMERGENCY 0.000000 243, 362 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 0 97 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 97.00 0

0.000000

5, 292, 007

98.00 0

0 200.00

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0183 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/19/2018 11:06 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. 267417 1, 566, 881 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0.000000 Ω O 52 00 0 05300 ANESTHESI OLOGY 53.00 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 110768 2, 417, 939 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 Ω 0 0 05600 RADI OI SOTOPE 56.00 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.000000 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 59 00 0 0 60.00 06000 LABORATORY 0.105317 0 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 62 00 0.000000 0 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. 129423 213, 495 65.00 0 06600 PHYSI CAL THERAPY 0.311400 66.00 344 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 C 0 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 C 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0.138735 136, 392 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.151163 1, 663, 029 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.091328 551, 603 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.297216 1,080,848 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 C 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 07698 WOUND CARE o 76. 98 0.729853 0 0 0 76. 98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0.000000 0 90.00 09000 CLI NI C 0.000000 C 0 0 90.00 0. 165036 91.00 09100 EMERGENCY 0 4, 455, 910 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 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 0 96.00 0 0 0 0 09700 DURABLE MEDICAL EQUIP-SOLD

0.000000

0.000000

0

13, 204, 552

13, 204, 552

0

0

0

97.00

200. 00

201 00

0 202. 00

0

0 98.00

0

0

97.00

98.00

200.00

201.00

202.00

09850 OTHER REIMBURSABLE COST CENTERS

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Provider CCN: 15-0183 Peri od: Worksheet D From 01/01/2017 Part V To 12/31/2017 Date/Ti me Prepared: 5/19/2018 11:06 am

				10 12/01/201/	5/19/2018 11:	06 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
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						
50. 00 05000 OPERATING ROOM	419, 011	0				50.00
51. 00 05100 RECOVERY ROOM	0	o				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o				52. 00
53. 00 05300 ANESTHESI OLOGY	0	o				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	267, 830	0				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI OI SOTOPE	0	o o				56. 00
57. 00 05700 CT SCAN	0	o				57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	o				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	Ö				59.00
60. 00 06000 LABORATORY	117, 756	0				60.00
60. 01 06001 BLOOD LABORATORY	117,730	0				60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	١				61.00
	0					1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	07 (21	0				64. 00
65. 00 06500 RESPIRATORY THERAPY	27, 631	0				65.00
66. 00 06600 PHYSI CAL THERAPY	107	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	18, 922	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	251, 388	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	50, 377	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	321, 245	0				73. 00
74. 00 07400 RENAL DI ALYSI S	0	0				74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 98 07698 WOUND CARE	0	0				76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 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	0	0				90. 00
91. 00 09100 EMERGENCY	735, 386	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	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				96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o				97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	o				98. 00
200.00 Subtotal (see instructions)	2, 209, 653	ol				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	2, 209, 653	o				202. 00
, , ,		. '				•

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0183	From 01/01/2017	Worksheet D-1 Date/Time Prepared: 5/19/2018 11:06 am		
	Title XVIII	Hospi tal	PPS		

PART 1			Ti +1 o V/// /	Hospi tal	5/19/2018 11: PPS	06 am
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description	Title XVIII	Hospi tal	PP5	
INPARTENT DAYS		·			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 3,299 1,00						
Inpatient days (including private room days, excluding saing-bed and newborn days) 3,299 2,000 3,00 Private room days (secularing saing-bed and observation bed days) 1 ryou have only private room days, 3,299 4,000 3,000 4 not complete this il rise. 3,299 4,000 3,000	1 00		excluding newborn)		3 299	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this file. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if call ender year, enter 0 on this line). 7.00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if call ender year, enter 0 on this line). 8.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if call ender year, enter 0 on this line). 9.00 Swing-bed SW type inpatient days (including private room days) after December 31 of the cost and the swing-bed swing-bed swing-bed swing-bed swing-bed swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newborn days). 10. Swing-bed SW type inpatient days applicable to title XVIII and y (including private room days) after swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 11. OS swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 12. OS Swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 13. OS Swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 14. OS Swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 15. OS Swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 16. OS Swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 17. OS Swing-bed SW type inpatient days applicable to title XVIII and y (including private room days). 18. OS Wing-bed W type inpatient days applicable to title XVIII and y (including private room days). 18. OS Wing-bed W type inpatient days applicable t						
5.299 4.00 5.00 Total swin,p-bed SF type inpatient days (including private room days) after December 31 of the cost reporting period of the swin of th	3.00			ivate room days,		3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 0 6.00		· ·				
reporting period (if calendar year, enter 0 on this line) 7.00 Total swin, bed SMF type inpatient days (including private room days) after December 31 of the cost 1 period (if calendar year, enter 0 on this line) 8.00 Total swin, bed NF type inpatient days (including private room days) through December 31 of the cost 1 period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days) after December 31 of the cost 1 period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 2, 197 9, 00 newborn days) 10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding private room days) 11.00 Swing-bed SMF type inpatient days applicable to the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SMF type inpatient days applicable to title SV or XIX only (including private room days) after 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) after 14.00 SWing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) after 15.00 SWing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) after 15.00 SWing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) after 15.00 SWing-bed MF type inpatient days applicable to the Program (excluding swing-bed sys) 13.00 SWing-bed SWI services applicable to services through December 31 of the cost 10.00 SWING-BWING SWING SWI				r 21 of the cost		
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period Power of the	5.00		on days) through becembe	i 31 of the cost	O	3.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 2.197 0.00 Non-bed SNF type inpatient days applicable to 1 tile XVIII only (including private room days) 10.00 Non-bed SNF type inpatient days applicable to 1 tile XVIII only (including private room days) after 0.11.00 Non-bed SNF type inpatient days applicable to 1 tile XVIII only (including private room days) after 0.11.00 Non-bed SNF type sarvices applicable to 1 tile XVIII only (including private room days) 0.12.00 Non-bed SNF type sarvices applicable to 1 tile XVIII only (including private room days) 0.12.00 Non-bed NF type inpatient days applicable to 1 tile XVIII only (including private room days) 0.13.00 Non-bed NF type inpatient days applicable to 1 tile XVIII only (including private room days) 0.13.00 Non-bed NF type inpatient days applicable to 1 tile XVIII only (including private room days) 0.15.00 Non-bed NF type inpatient days applicable to 1 tile XVIII only (including private room days) 0.15.00 Non-bed NF type inpatient days applicable to 1 tile XVIII only (including private room days) 0.15.00	6.00		om days) after December	31 of the cost	0	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this iline) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed Simbler 31 of the cost reporting period (see instructions) 11. 00 Swing-bed Simbler 31 of the cost reporting period (see instructions) 12. 00 Swing-bed Simbler 31 of the cost reporting period (see instructions) 13. 00 Swing-bed Simbler 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Swing-bed Simbler 31 of the cost reporting period (if calendar year, enter 0 on this line) 15. 00 Swing-bed Simbler 31 of the cost reporting period (if calendar year, enter 0 on this line) 16. 00 Swing-bed Simbler 31 of the cost reporting period (if calendar year, enter 0 on this line) 17. 00 Swing-bed Simbler 31 of the cost reporting period (if calendar year, enter 0 on this line) 18. 00 Swing-bed Simbler 31 of the cost reporting period (if calendar year, enter 0 on this line) 18. 00 Indically necessary private room days applicable to titles V or XIX only (including private room days) 18. 00 Indical nursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery days (if lie V or XIX only) 18. 00 Indical rursery day					_	
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line)	7.00		n days) through December	31 of the cost	0	7.00
reporting period (if callendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (cluding private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (cluding private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after 20.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 20.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after 20.00 After December 31 of the cost reporting period (including private room days) after 20.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 20.00 Swing-bed SNF type inpatient days applicable to the Program (excluding Swing-bed days) 13.00 Swing-bed SNF services applicable to the Program (excluding Swing-bed days) 14.00 Swing-Bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 15.00 Swing-Bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 15.00 Swing-Bed SNF services applicable to services after December 31 of the cost reporting period (line 20.00 Swing-Bed SNF services applicable to services after December 31 of the cost reporting period (line 20.00 Swing-Bed SNF services after December 31 of the cost reporting period (line 20.00 Swing-Bed SNF services after December 31 of the cost reporting period (line 20.00 Swing-Bed SNF services after December 31 of the cost reporting period (line 20.00 Swing-B	8.00		n davs) after December 3	1 of the cost	0	8. 00
newborn days 0 10.00 1						
10.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) on through December 31 of the cost reporting period (see instructions) on this line) on the cost reporting period (see instructions) on the cost cost of the cost reporting period (see instructions) on the cost of the cost reporting period (see instructions) on the cost of the cost reporting period (see instructions) on the cost of the cost reporting period (see instructions) on the cost of the cost reporting period (see instructions) on the cost of the cost reporting period (see instructions) on the cost of the cost reporting period (see instructions) on the cost of the cost reporting period (see instructions) on the cost of the	9.00		the Program (excluding	swing-bed and	2, 197	9. 00
through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Norsery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed days) 18.00 Norsery days (title V or XIX only) 19.00 Norsery days (tit	10 00		alv (including private r	oom dave)	0	10 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00	10.00			oom days)	O	10.00
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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) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 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 4, 109, 854) 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 (line 9 x line 38) 79.00 Program general inpatient routine service cost (line 9 x line 38) 80.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0000000 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 35.00 0.00 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 4, 109, 854) 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 (line 9 x line 38) 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00		- line 28)		0.000000	
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 4, 109, 854) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
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 4, 109, 854) 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) 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
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 4, 109, 854) 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) 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 36.00 4, 109, 854 4, 109, 854 37.00 37.00 37.00 4, 109, 854 4, 109, 854 4, 109, 854 5, 100 5, 100 6,	34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 109, 854) 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) 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) 37.00 2, 737, 001 37.00	35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
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) 1, 245.79 38.00 Program general inpatient routine service cost (line 9 x line 38) 2, 737, 001 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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) 1, 245.79 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	,	and private room cost di	tterential (line	4, 109, 854	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 245.79 38.00 Program general inpatient routine service cost (line 9 x line 38) 2, 737, 001 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
Adjusted general inpatient routine service cost per diem (see instructions) 1, 245.79 38.00 Program general inpatient routine service cost (line 9 x line 38) 2, 737, 001 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1, 245.79 38.00 2, 737, 001 39.00			ISTMENTS			
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) 2,737,001 39.00 40.00	38. 00				1, 245. 79	38. 00
	39. 00	, , , , , , , , , , , , , , , , , , , ,	•		2, 737, 001	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,737,001 41.00						
	41. 00	lotal Program general inpatient routine service cost (line 39	+ IIne 40)		2, 737, 001	41.00

	Financial Systems	MONROE HO				-		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi dei	r CC	CN: 15-0183	Perio From	d: 01/01/2017	Worksheet D-1	
							12/31/2017		
				tle	XVIII		ospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	21/6	Average Per	Pro	gram Days	Program Cost (col. 3 x col.	
		Impatrent cost	inpatr cirt b	ays	col . 2)			4)	
12.00	NUDSERV (+i+Lo V & VIV onLy)	1.00	2. 00	0	3.00	00	4. 00	5.00	42. 0
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> </u>		<u> </u>	0. 0	00		<u> </u>	42.0
43. 00	INTENSIVE CARE UNIT	1, 817, 728		921	1, 973.		151	1	
44. 00 45. 00	CORONARY CARE UNIT	0 0		0	0. (0. (0	1	
	SURGICAL INTENSIVE CARE UNIT	l o		0	0. (1	0	1	1
47. 00	OTHER SPECIAL CARE (SPECIFY)								47.0
	Cost Center Description							1.00	
48. 00	Program inpatient ancillary service cost (Wk				_			3, 786, 865	
19. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruc	ti o	ns)			6, 821, 887	49.0
50. 00	Pass through costs applicable to Program inp.	atient routine	services (f	rom	Wkst. D, sur	m of Pa	arts I and	463, 314	50.0
1 00	Dass through costs applicable to Drogram in	ationt ancillar	u corul coc	(fr	om Wkst D	cum of	Dorte II	127 401	E1 C
51. 00	Pass through costs applicable to Program inpand IV)	аттент ансптаг	y services	CIL	UIII WAST. D, S	oun Of	rai tS II	437, 684	51.0
52.00	Total Program excludable cost (sum of lines							900, 998	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-	phy	sician anesth	hetist	, and	5, 920, 889	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	,							
54. 00 55. 00	Program discharges Target amount per discharge							0	54. C
6. 00	Target amount (line 54 x line 55)							0.00	1
7. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount	(1	ine 56 minus	line	53)	0	1
8. 00 9. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996) []	ndated and co	ompoun	ded by the	0 00	58. (59. (
	market basket		J			·	aca 25 the		
50. 00 51. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line						mount by	0.00	60. 0 61. 0
31.00	which operating costs (line 53) are less than								01.0
2 00	amount (line 56), otherwise enter zero (see	instructions)						0	62.0
52. 00 53. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)					0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST								1
54. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 or	τne	cost reporti	ing pe	rioa (See	0	64.0
55.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of th	e c	ost reportino	g peri	od (See	0	65. C
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus lin	ne 6	5)(title XVII	II onl	v) For	0	66.0
30.00	CAH (see instructions)		•			,			
57. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 3	11 o	f the cost re	eporti	ng period	0	67.0
58. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31	of	the cost repo	orting	peri od	0	68. 0
50 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino costs (lino 67 . l	i no	60)			_	69. 0
9. 00	PART III - SKILLED NURSING FACILITY, OTHER NI							0	09.0
70.00	Skilled nursing facility/other nursing facil)			70.0
1. 00 2. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷ Ii	ne :	2)				71. 0
3. 00	Medically necessary private room cost applic		(line 14 x	Hi	ne 35)				73.0
4.00	Total Program general inpatient routine serv	•			orksboot P. [Dort I	l column		74. (
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	CUSIS (TPO	oili VV	urksneet B, F	rait I	i, corumn		75.0
6. 00	Per diem capital-related costs (line 75 ÷ li								76.0
7. 00 8. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu								77. 0
9. 00	Aggregate charges to beneficiaries for exces		rovi der rec	ord	s)				79. 0
0.00	Total Program routine service costs for comp	arison to the c				nus li	ne 79)		80.0
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)						81. (
3. 00	Reasonable inpatient routine service costs (83. 0
84.00	Program inpatient ancillary services (see in		20)						84. (
35. 00 36. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum								85. 0 86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST							
37. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		1: 2)					1	87. C
38. 00									

Health Financial Systems	MONROE HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/19/2018 11:0	pared: 06 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	610, 629	4, 109, 854	0. 14857	7 0	0	90.00
91.00 Nursing School cost	0	4, 109, 854	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 109, 854	0.00000	o o	0	92.00
93.00 All other Medical Education	0	4, 109, 854	0.00000	o o	0	93.00

Health Financial Systems	MONROE HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/19/2018 11:06 am
	Title XIX	Hospi tal	PPS

		Title XIX	Hospi tal	5/19/2018 11: PPS	06 am_
	Cost Center Description	II LIE XIX	nospi tai	FF3	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		3, 299	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 299	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4 00	do not complete this line.	- d - dX		2 200	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		21 of the cost	3, 299 0	4. 00 5. 00
5.00	reporting period	olii days) trii ougii becellibei	31 OF THE COST	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	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 roor	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 2	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter beceiiber s	i or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	68	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Join days) arter		11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exertaining swring bea	ady 3)	0	15. 00
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 service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	as after December 31 of	the cost	0.00	18. 00
10.00	reporting period	23 di tei becember 31 di	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	6. 5 6. 6.			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		4, 109, 854	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost reportion	na period (line	0	24. 00
24.00	7 x line 19)	or the cost reporter	ig perrou (Trie		24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.00
0/ 00	x line 20)				0/ 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 4, 109, 854	26. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 lilitius Title 20)		4, 107, 654	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	4, 109, 854	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 245. 79	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			84, 714	
40.00	Medically necessary private room cost applicable to the Progra	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	l	84, 714	41.00

Heal th	Financial Systems	MONROE HOS	SPI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		_	CCN: 15-0183	Peri od:	Worksheet D-1	
					From 01/01/2017 To 12/31/2017		pared:
-			т:	tto VIV	Hospi tal	5/19/2018 11:	06 am_
	Cost Center Description	Total	Total	tle XIX Average Pe		PPS Program Cost	
		Inpatient Cost		ays Diem (col.		(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00		. 00 C		42. 00
	Intensive Care Type Inpatient Hospital Units	-		-		_	
43. 00	INTENSIVE CARE UNIT	1, 817, 728	Ç	921 1, 973			
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		•	. 00 . 00		44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT			•	. 00		46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1. 00 875, 853	48. 00
	Total Program inpatient costs (sum of lines			tions)		978, 330	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine s	ervices (fr	rom Wkst D s	um of Parts I and	15, 963	50. 00
			•	·			
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	servi ces	(from Wkst. D,	sum of Parts II	107, 449	51. 00
52.00	Total Program excludable cost (sum of lines					123, 412	•
53. 00	Total Program inpatient operating cost exclu	9 1	ated, non-p	ohysi ci an anes	thetist, and	854, 918	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54. 00
55.00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	net amount	(line 56 minu	s line 53)	0 0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and tar	get amount	(TTHE GO IIITHG	3 11110 00)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996,	updated and	compounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	ated by the	e market haske	+	0.00	60. 00
	If line 53/54 is less than the lower of line					0.00	61. 00
	which operating costs (line 53) are less tha		(lines 54	x 60), or 1%	of the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00		ent (see instruc	tions)			0	
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +b	h 01 1	Ll	ti		(4.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through becein	ber 31 or	the cost repor	tring period (see	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	r 31 of the	e cost reporti	ng period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line	e 65)(title XV	III only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	o costs through	Docombor 2	1 of the cost	roporting poriod	0	67. 00
	(line 12 x line 19)	3			. 3.		
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 d	of the cost re	porting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	<u> </u>				0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				7)		70. 00
71. 00	Adjusted general inpatient routine service c				, ,		71. 00
72. 00	Program routine service cost (line 9 x line			>			72. 00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75. 00
7/ 00	26, line 45)	0)					7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for exces						79. 00
80.00	Total Program routine service costs for comp.		st limitati	on (line 78 m	inus line 79)		80. 00 81. 00
81.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81.00
83. 00	Reasonable inpatient routine service costs (83. 00
84.00	Program inpatient ancillary services (see in		->				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 60	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					33. 30
87. 00	Total observation bed days (see instructions		11 0			0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	iine 2)				88. 00 89. 00
_ /. 00	(30)					'	50

Health Financial Systems	MONROE HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/19/2018 11:	pared: 06 am_
		Ti tl	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	610, 629	4, 109, 854	0. 14857	7 0	0	90. 00
91.00 Nursing School cost	0	4, 109, 854	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 109, 854	0.00000	o o	0	92. 00
93.00 All other Medical Education	0	4, 109, 854	0.00000	o o	0	93. 00

Health Financial Systems MONROE HOSPI	TAL		In Lie	u of Form CMS-:	<u>2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	}
			From 01/01/2017	D . (T) D	
			To 12/31/2017		
	T: 41 -		11: 4-1	5/19/2018 11:	<u>06 am</u>
	II LIE	XVIII	Hospi tal	PPS	
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					
30. 00 03000 ADULTS & PEDI ATRI CS			2, 634, 939		30.00
31.00 03100 NTENSIVE CARE UNIT			427, 194		31.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL 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
			O O		43.00
					43.00
ANCILLARY SERVICE COST CENTERS		0.0/744	2 0.057 407	074 407	
50. 00 05000 OPERATI NG ROOM		0. 26741		871, 107	1
51. 00 05100 RECOVERY ROOM		0.00000		0	1
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
53. 00 05300 ANESTHESI OLOGY		0.00000	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11076	8 2, 016, 404	223, 353	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0.00000		0	
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)		0.00000		Ō	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		Ö	1
60. 00 06000 LABORATORY		0. 10531			
		•			1
60. 01 06001 BLOOD LABORATORY		0.00000		0	
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY		0.00000		0	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	1
64.00 06400 INTRAVENOUS THERAPY		0.00000	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 12942	3 2, 789, 126	360, 977	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 31140	0 355, 865	110, 816	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 13873		89, 291	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 15116			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 09132			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29721		508, 376	
		1			1
74. 00 07400 RENAL DI ALYSI S		0.00000		0	1
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	1
76. 98 07698 WOUND CARE		0. 72985		0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
90. 00 09000 CLI NI C		0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY		0. 16503		184, 356	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.00000		0	•
OTHER REIMBURSABLE COST CENTERS		0.00000	0 0		72.00
		0.00000		0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000			
95. 00 09500 AMBULANCE SERVI CES			_	_	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	•
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000	0	0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			24, 323, 085	3, 786, 865	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	-		24, 323, 085		202. 00
		•		•	•

Health Financial Systems Monroe Hose			U OT FORM CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0183	Peri od:	Worksheet D-3	
		From 01/01/2017		
		To 12/31/2017		
			5/19/2018 11:0	06 am_
	Title XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Cos	t Inpatient	Inpati ent	
	To Charges	Program	Program Costs	
	l to charges	Charges	(col. 1 x col.	
		Charges		
	1.00		2)	
	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		577, 265		30.00
31.00 03100 INTENSIVE CARE UNIT		95, 356		31.00
32. 00 03200 CORONARY CARE UNI T		0		32. 00
33. 00 03300 BURN I NTENSI VE CARE UNI T				33.00
		0		1
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT		0		34. 00
40. 00 04000 SUBPROVI DER - 1 PF		0		40. 00
41. 00 04100 SUBPROVI DER - I RF		0		41.00
43. 00 04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS		•	•	İ
50. 00 05000 OPERATING ROOM	0. 2674	17 1, 021, 011	273, 036	50.00
	•			1
51. 00 05100 RECOVERY ROOM	0.0000		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0.0000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0.0000	00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1107	58 299, 931	33, 223	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.0000		0	55.00
56. 00 05600 RADI OI SOTOPE	0.0000		Ö	56.00
	•			•
57. 00 05700 CT SCAN	0.0000		0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.0000	00 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.0000	00	0	59. 00
60. 00 06000 LABORATORY	0. 1053	17 482, 534	50, 819	60.00
60. 01 06001 BL00D LABORATORY	0.0000		0	60. 01
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0.0000		o o	61. 00
	•			•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.0000		0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.0000	00 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0.0000	00	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 1294	23 391, 899	50, 721	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 3114		11, 186	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.0000		0	67. 00
	•			1
68. 00 06800 SPEECH PATHOLOGY	0.0000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 1387		8, 308	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.0000	00	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 1511	1, 029, 776	155, 664	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 0913	1, 266, 531	115, 670	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 2972			73. 00
	•			1
	0.0000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0.0000		0	75. 00
76. 98 07698 WOUND CARE	0. 7298	53 0	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.0000	00	0	77. 00
OUTPATIENT SERVICE COST CENTERS				Ī
88. 00 08800 RURAL HEALTH CLINIC	0.0000	00 0	0	88. 00
	•			
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.0000			89. 00
90. 00 09000 CLI NI C	0. 0000		0	90. 00
91. 00 09100 EMERGENCY	0. 1650	36 243, 362	40, 163	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0.0000	00 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			1
94. 00 09400 HOME PROGRAM DI ALYSI S	0.0000	00	0	94. 00
	0.0000	50		1
95. 00 09500 AMBULANCE SERVI CES		-	_	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.0000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.0000		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0.0000	00 0	0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		5, 292, 007	875, 853	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(Line 61)	n, , 507		201. 00
202.00 Net charges (line 200 minus line 201)	(1.1.0 0.7)	5, 292, 007		202.00
202. 00 Not charges (Trine 200 IIII lias Trine 201)	ı	5, 272, 007	1	1202.00

		Title XVIII	Hospi tal	5/19/2018 11:0 PPS	06 am_
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (s	see	4, 042, 313	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	on or after October 1	(see	1, 087, 194	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for c 1 (see instructions)	li scharges occurri ng p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for clotober 1 (see instructions)	lischarges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			1, 585, 778 0	2. 00 2. 01
2. 01	Outlier payment for discharges for Model 4 BPCI (see instructions	;)		0	2. 01
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 instruc	ctions)	32.00	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most re or before 12/31/1996. (see instructions)	cent 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-c	on to the cap	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified unde			0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.	CFR §412. 105(f)(1)(i	/)(B)(2) If the	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 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	from a closed teaching	ng hospital	0. 00	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	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podiatric programs.	year from your record	ls	0.00	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)				12.00
13. 00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year entherwise enter zero.	ended on or after Sept	cember 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			0. 00	16. 00
	Adjustment for residents displaced by program or hospital closure	;			17. 00
	Adjusted rolling average FTE count				18.00
	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
	IME payment adjustment (see instructions)			0.000000	22. 00
	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of	the MMA		-	
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.	cap slots under 42 CF	R 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	25. 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
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruct	i ons)	4. 92	
	Percentage of Medicaid patient days (see instructions)				31.00
32. 00 33. 00	Sum of lines 30 and 31			19. 00 5. 10	
	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			65, 402	
= =	, , , , , , , , , , , , , , , , , , ,		'	55, .02	==

	Financial Systems MONROE ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0183	Peri od:	wof Form CMS-2 Worksheet E	<u> 2002-10</u>
			From 01/01/2017 To 12/31/2017	Part A Date/Time Prep 5/19/2018 11:0	pared:
		Title XVIII	Hospi tal	PPS	. ani
			Prior to 10/1 1.00	On/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		5, 977, 483, 147		
35. 01 35. 02	Factor 3 (see instructions)	enter zero en this line) (se	0. 000007386	0. 000042261	35. 01 35. 02
33. 02	Hospital uncompensated care payment (If line 34 is zero, instructions)	enter zero on this rine) (se	ee 44, 150	285, 967	35.02
35. 03 36. 00	Pro rata share of the hospital uncompensated care paymen Total uncompensated care (sum of columns 1 and 2 on line	35. 03)	33, 022 105, 101	72, 079	35. 03 36. 00
40.00	Additional payment for high percentage of ESRD beneficial		gh 46) 626		40.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluded 652, 682, 683, 684 and 685 (see instructions)	uring di schai ges 101 ms-bros	020		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 6 instructions)	82, 683, 684 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding an 685. (see instructions)				41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not or Total Medicare ESRD inpatient days excluding MS-DRGs 65. instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 dividays)	ided by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instruc		447. 81		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	ne 41.01)	6, 885, 788		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MI only. (see instructions)	DH, small rural hospitals	0, 663, 766		48. 00
	join y. (See Fristructions)			Amount	
40.00	Total payment for innations approxima costs (see instruc	ti ana)		1. 00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt.	•		6, 885, 788 745, 925	
51.00	Exception payment for inpatient program capital (Wkst. L.	, Pt. III, see instructions)		0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-Nursing and Allied Health Managed Care payment	4, line 49 see instructions).		0	52. 00 53. 00
54. 00	Special add-on payments for new technologies			0	54.00
54. 01	Islet isolation add-on payment			0	54. 01
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, II Cost of physicians' services in a teaching hospital (see			0	55. 00 56. 00
57. 00	Routine service other pass through costs (from Wkst. D.	•	hrough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D,		<i>3</i> ,	0	58. 00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58)			7, 631, 713	1
61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 m	minus line 60)		3, 474 7, 628, 239	
62.00	Deductibles billed to program beneficiaries	,		620, 984	62. 00
63.00				20, 069	
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
66. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6, 987, 186	
68.00	Credits received from manufacturers for replaced devices			0	
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	96). (For SCH see Instruction	is)	0	69. 00 70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A De	monstration) adjustment (see	instructions)	0	70.50
70. 87	Demonstration payment adjustment amount before sequestra	ti on		0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use on	3,		0	
70. 89	Pioneer ACO demonstration payment adjustment amount (see HSP bonus payment HVBP adjustment amount (see instruction			0	70. 89 70. 90
70 90	HSP bonus payment HRR adjustment amount (see instructions			0	
70. 90 70. 91				ا م	
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	
70. 91	HVBP payment adjustment amount (see instructions)			0	70. 93

93.00 Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00 The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00 Time value of money for operating expenses (see instructions)		0	95.00
96.00 Time value of money for capital related expenses (see instructions)		0	96.00
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			i
101.00 HVBP adjustment factor (see instructions)	0.000000000	0.0000000000	101. OC
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment			Ī
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			Ī
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the cur	rrent 5-year demonst	trati on	1
peri od)			4
204.00 Medicare target amount		l .	204.00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			4
207.00 Program reimbursement under the §410A Demonstration (see instructions)		l	207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)		l	208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)		l	209. 00
210.00 Reserved for future use			210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)			213.00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement))		218. 00
(line 212 minus line 213) (see instructions)			

PART B . MEDICAL AND OTHER HAITH SERVICES 1.00				10 12/01/201/	5/19/2018 11:	
New Teach and other services (see Instructions)			Title XVIII	Hospi tal	PPS	
New Teach and other services (see Instructions)					1.00	
		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
Medical and other services relabursed under OPPS (see Instructions) 2,877,918 2,00	1.00				63	1.00
0.00 1.00			tions)			
0.00	3.00	OPPS payments			1, 781, 452	3. 00
Enter the hospital specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)			109, 128	4. 00
Line 2 times line 5		· · · · · · · · · · · · · · · · · · ·				
2.00 Sum of Fines 3, 4, and 4.01, divided by line 6 0.00 7.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 7.00 8.00 7.00		, , , , , , , , , , , , , , , , , , , ,	ctions)			1
1.00 Control						1
						1
0.00 Organ acquisitions 0.00 0.00		, , , , , , , , , , , , , , , , , , , ,	IV ool 12 line 200			ł
1.00 Total cost (sum of lines 1 and 10) (see instructions) 6.5 10.00			IV, COI. 13, TIME 200			ı
COMPUTATION OF LESSER OF COST OR CHARCES Reasonable charges						ł
Reasonable charges 212 12.00 212 13.00 212 13.00 213 213	11.00				. 03	11.00
2.00 Ancil larry service charges 212 12.00 10 10 10 10 10 10 10						
13.00 organ acquisition charges (from Wist. D-4, Pt. III., col. 4, line 69) 13.00 13.0	12. 00	<u> </u>			212	12.00
14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 212 14.00 215 216 200			ine 69)			1
15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00 16.00 Abd such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17.00	14.00		•		212	14. 00
16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis Nature						
had such payment been made in accordance with 42 CFR §413. 13(e)	15. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15. 00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00	16. 00			n a chargebasis	0	16. 00
18.00 Total customery charges (see instructions) 21 18.00 149 19.00 20.0			e)			
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 149 19. 00		,				ł
Instructions				44) (ł
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19.00		TY IT TIME 18 exceeds II	ne II) (see	149	19.00
Instructions 6.3 21.00 22.00 Interns and residents (see instructions) 0.22.00 23.00 Cot of physic clans' services in a teaching hospital (see instructions) 0.22.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 1,890,580 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 1,890,580 25.00 Deductibles and coinsurance (for CAH, see instructions) 4.2 25.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 384,367,26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 1,506,234 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0.28,00 29.00 ESRO direct medical education costs (from Wkst. E-4, line 36) 0.29,00 29.00 ESRO direct medical education costs (from Wkst. E-4, line 36) 0.29,00 29.01 Primary payer payments 1,506,234 29.00 Primary payer payments 1,506,234 29.00 Primary payer payments 1,376 31.00 Composite rate ESRO (from Wkst. I5, line 11) 1,504,858 31.00 Composite rate ESRO (from Wkst. I5, line 11) 0.33,00 30.00 Allowable bad debts (see instructions) 0.35,00 30.00 Allowable bad debts (see instructions) 0.36,00 30.00 Allowable bad debts (see instructions) 0.36,00 30.00 MSP-LCC reconciliation amount from PSR 377,38,00 30.00 MSP-LCC reconciliation amount from PSR 379,38,00 30.00 ORD (Free ADUSTINEMINS (SEE INSTRUCTIONS) 0.39,90 30.00 ORD (Free ADUSTINEMINS (SEE INSTRUCTIONS) 0.30,00 30.00 ORD (Free ADUSTINEMINS (SEE INSTRUCTIONS) 0.30,00 3	20.00		Ly if line 11 exceeds li	no 10) (coo	1	20 00
21.00 Lesser of cost or charges (see instructions) 6.3 21.00 22.00	20.00		Ty IT TITLE IT EXCEEDS IT	ne 10) (See		20.00
22.00 Interns and residents (see instructions) 0 22.00 23.00 Cost of physic lands (seve in a treaching hospital (see instructions) 0 23.00 23.00 Cost of physic lands (sum of lines 3, 4, 4.01, 8 and 9) 1,890,580 24.00 Computation of Ref Insulsablement SETILEMENT 1,890,580 24.00 Computation of Ref Insulsablement SETILEMENT 25.00 Deductibles and coinsurance (for CAH, see instructions) 34.00 25.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 384,367 26.00 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 384,367 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see linstructions) 1,506,234 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0,28.00 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0,29.00 29.00	21. 00				63	21. 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 1,890,580 24.00 24.00 24.00 24.00 24.00 25.00						ł
24. 00 Total prospective payment (sum of lines 3, 4, 4. 01, 8 and 9) 1,890,580 24. 00		, ,	ructions)		0	ł
COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00	24.00		,		1, 890, 580	24. 00
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 384, 367 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 1,506, 234 27.00 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 28.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 29.00 29.00 Subtotal (sum of lines 27 through 29) 1,506, 234 30.00 29.00 2						
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	25. 00	Deductibles and coinsurance (for CAH, see instructions)			42	25. 00
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) Direct graduate medical education costs (from Wkst. E-4, line 36) 0 28.00 29.00		,				ı
28. 00	27. 00		plus the sum of lines 22	and 23] (see	1, 506, 234	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27 through 29) 1,506,234 30.00 30.00 30.00 All own of lines 27 through 29) 1,504,858 32.00 All own of lines 20 minus line 31) 31.00 All own of lines 30 minus line 31) 32.00 All own of lines 30 minus line 31) 32.00 All own of lines 30 minus line 31) 33.00 34.00 All own of lines 30 minus line 31) 33.00 34.00 All own of lines 30 minus line 31) 34.00 All own of lines 30 minus line 31) 35.00 Adjusted reimbursable bad debts (see instructions) 0 34.00 35.00 All own of lines 30 minus line 31) 34.00 34.		,			_	
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31.00 Primary payer payments 1,376 31.00 32.00 Subtotal (line 30 minus line 31) 1,504,858 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 0 35.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 0 36.00 38.00 MSP-LCC reconciliation amount from PS&R 37.20 38.00 MSP-LCC reconciliation amount from PS&R 37.20 39.50 39.97 Demonstration payment adjustment (see instructions) 39.90 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.00 40					-	ł
32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 0 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 37.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00		,				1
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36.00	34.00				0	34.00
37.00 Subtotal (see instructions) 1,504,858 37.00 38.00 MSP-LCC reconciliation amount from PS&R 372 38.00 39.00 39.00 39.50 39.50 39.50 39.97 39.97 39.98 39.00 39.97 39.98 39.00 39.97 39.98 39.00 39.97 39.98 39.00 39.97 39.98 39.00 39.97 39.98 39.00 39.98 39.00 39.97 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.98 39.00 39.00 39.98 39.00 39.00 39.98 39.00 39.00 39.98 39.00 39.00 39.99 39.00 39.00 39.00 39.99 39.00 39.00 39.00 39.99 39.00 39	35.00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
38.00 MSP-LCC reconciliation amount from PS&R 372 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39. 97 Demonstration payment adjustment amount before sequestration 0 39.97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40. 00 Subtotal (see instructions) 1,504,486 40.00 40. 01 Sequestration adjustment (see instructions) 30,090 40.01 40. 02 Demonstration payment adjustment amount after sequestration 0 40.02 41. 00 Interim payments 1,474,390 40.02 42. 00 Interim payments 1,474,390 41.00 43. 00 Bal ance due provider/program (see instructions) 6 43.00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90. 00 Original outlier amount (see instructions) 0 90.00	36.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	36. 00
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\	37.00	Subtotal (see instructions)			1, 504, 858	37. 00
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39. 97 39. 98 39. 99 Recovery of Accelerated Depreciations) 39. 99 40. 00 Subtotal (see instructions) 30. 99 40. 01 Sequestration adjustment (see instructions) 30. 99 40. 02 Demonstration payment adjustment (see instructions) 30. 99 40. 01 Interim payment adjustment amount after sequestration 40. 02 Interim payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5}{115} \cdot 2\$ To BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 1, 474, 390 91. 00 Qutlier reconciliation adjustment amount (see instructions) 0 90. 00 91. 00 The rate used to calculate the Time Value of Money 92. 00 Time Value of Money (see instructions) 0 93. 00		OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
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40.00 Subtotal (see instructions) 1,504,486 40.00 40.01 Sequestration adjustment (see instructions) 30,090 40.01 40.02 41.00 Interim payments 1,474,390 41.00 42.00 Tentative settlement (for contractors use only) 42.00 8al ance due provider/program (see instructions) 6 43.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 8115.2 10.00 10		l '	ced devices (see instruc	tions)		
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40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 1,474,390 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Balance due provider/program (see instructions) 6 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00		,				•
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42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 91.50 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 O 93.00		, , , , , , , , , , , , , , , , , , , ,				•
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\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)		, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub 15-2	chanter 1		1
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92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,			0	91.00
	92.00	,			0.00	92.00
94.00 Total (sum of lines 91 and 93) 0 94.00		,				
	94. 00	Total (sum of lines 91 and 93)			0	94.00

Peri od: Worksheet E-1
From 01/01/2017
To 12/31/2017 Part I
Date/Time Prepared: 5/19/2018 11:06 am Provider CCN: 15-0183

					5/19/2018 11:0	06 am_
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A		⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		6, 818, 730		1, 474, 390	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,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				•	
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3.02			(D	0	3. 02
3.03			(D	0	3. 03
3.04				D	0	3. 04
3.05			(0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51				O C	0	3. 51
3. 52					0 0	3. 52
3. 53 3. 54						3. 53 3. 54
3. 54	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 54
3. 77	3. 50-3. 98)		,			3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		6, 818, 730		1, 474, 390	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as		.,,		, ,	
	appropri ate)					
	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)					
E 01	Program to Provider TENTATIVE TO PROVIDER		,		1 0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
5.05	Provider to Program			21		5. 05
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(o	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
	the cost report. (1)		00			
6. 01	SETTLEMENT TO PROVIDER		28, 712		6	6. 01
6.02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)		6, 847, 442		1, 474, 396 NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
	T. T			1		

Heal th	Financial Systems MONROE HOSI	PI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0183	Peri od: From 01/01/2017	Worksheet E-1 Part II	
			To 12/31/2017	Date/Time Pre	
				5/19/2018 11:	06 am_
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)				31.00
32 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ne)		32 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0183	Period: Worksheet E-3 From 01/01/2017 Part VII
		To 12/31/2017 Date/Time Prepared:

		-	Γο 12/31/2017	Date/Time Pre 5/19/2018 11:	
		Title XIX	Hospi tal	PPS	
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI)	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, 209, 653	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, 209, 653	1
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, 209, 653	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges		(72 (21		8. 00
9. 00	Routine service charges Ancillary service charges		672, 621 5, 292, 007	12 204 552	
10. 00	Organ acquisition charges, net of revenue		5, 292, 007	13, 204, 552	10.00
	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		5, 964, 628	13, 204, 552	1
12.00	CUSTOMARY CHARGES		3, 704, 020	13, 204, 332	12.00
13. 00					
	basis				
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	2 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, 628	13, 204, 552	1
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	5, 964, 628	10, 994, 899	17. 00
18. 00	line 4) (see instructions)	u if line 4 evecede line	0	0	18. 00
16.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	y II IIIle 4 exceeds IIIle	U	U	16.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0	2, 209, 653	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of		ers.		
22.00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	2, 209, 653	29. 00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	2, 209, 653	
32. 00	Deductibles		0	2, 207, 033	1
33. 00			0	0	1
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, 209, 653	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38.00	Subtotal (line 36 ± line 37)		0	2, 209, 653	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		0	2, 209, 653	1
41. 00	Interim payments		0	0	
42. 00	Balance due provider/program (line 40 minus line 41)		0	2, 209, 653	1
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

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 01/01

| Period: | Worksheet G | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/19/2018 11:06 am

oni y)				1270172017	5/19/2018 11:	06 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	747, 604		0	0	
2.00	Temporary investments	0			0	
4.00	Notes recei vabl e Accounts recei vabl e	67, 968, 122	1	, i	0	
5.00	Other recei vable	7, 002, 481			0	
6.00	Allowances for uncollectible notes and accounts receivable	-63, 602, 113			0	
7. 00	Inventory	902, 735		o o	0	
8.00	Prepai d expenses	371, 113		o o	Ō	
9.00	Other current assets	24, 945		0	0	9.00
10.00	Due from other funds	0) (0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13, 414, 887	' (0	0	11.00
	FIXED ASSETS					
12.00	Land	1, 300, 000	1		-	1
13.00	Land improvements	0) (-	0	
14. 00	Accumulated depreciation	0) (1
15. 00	Bui I di ngs	8, 000, 000	•	-	0	
16. 00	Accumulated depreciation	-1, 599, 999	1	-	0	1
17. 00	Leasehold improvements	1, 506, 486	1	, i	0	
18.00	Accumulated depreciation	-654, 959	1	, i	0	
19.00	Fixed equipment	8, 440, 000	1		0	
20.00	Accumulated depreciation	-2, 387, 529	1	0	0	
21. 00	Automobiles and trucks	0		-	0	
22. 00	Accumulated depreciation	908, 029		-	0	
23. 00 24. 00	Maj or movable equipment	-783, 305	•	-	0	
25. 00	Accumulated depreciation	-763, 303		-	0	
26. 00	Minor equipment depreciable Accumulated depreciation			, i	0	
27. 00	HIT designated Assets				0	
28. 00	Accumulated depreciation				0	
29. 00	Mi nor equi pment-nondepreci abl e			-	0	
30.00	Total fixed assets (sum of lines 12-29)	14, 728, 723	1	-		
	OTHER ASSETS					1
31.00	Investments	0) (0	0	31.00
32.00	Deposits on Leases	0) (o	0	32.00
33.00	Due from owners/officers	0) (0	0	33.00
34.00	Other assets	415, 399		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	415, 399	ol c	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28, 559, 009)	0	0	36.00
	CURRENT LIABILITIES					
37. 00	Accounts payable	765, 908	1			
38. 00	Salaries, wages, and fees payable	1, 101, 202	1	-	0	
39. 00	Payroll taxes payable	108, 464	1	0	0	1
40.00	Notes and Loans payable (short term)	1, 349, 428	1	0	0	
41.00	Deferred income	95, 419		O O	0	
42.00	Accel erated payments	10 001 751	1		_	42.00
43. 00 44. 00	Due to other funds Other current liabilities	19, 801, 751	1	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	667, 891 23, 890, 063	1			
45.00	LONG TERM LIABILITIES	23, 690, 003)	0	45.00
46. 00	Mortgage payable	5, 000, 000		0	0	46. 00
47. 00	Notes payable	682, 931		-		
48. 00	Unsecured Loans	002, 731				1
49. 00	Other long term liabilities	11, 634, 706		-	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	17, 317, 637		-		
51.00	Total liabilities (sum of lines 45 and 50)	41, 207, 700				
	CAPITAL ACCOUNTS	,,				1
52.00	General fund balance	-12, 648, 691				52.00
53.00	Specific purpose fund					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	Plant fund balance - invested in plant		1		0	
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
				N 0		I EO OC
59. 00	Total fund balances (sum of lines 52 thru 58)	-12, 648, 691		۷	0	1
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 59)	-12, 648, 691 28, 559, 009		0	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES MONROE HOSPITAL

Provider CCN: 15-0183

					То	12/31/2017	Date/Time Prep 5/19/2018 11:0	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period	1100	-9, 178, 159			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3, 470, 531					2. 00
3.00	Total (sum of line 1 and line 2)		-12, 648, 690			0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00 9. 00		0			0		0	8. 00
10.00	Total additions (sum of line 4-9)	٩	0		U	0	U	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		-12, 648, 690			0		10.00
12. 00	ROUNDI NG	1	- 12, 040, 070		0	U	0	
13. 00	INCONDI NO	l ö			0			13. 00
14. 00					0			
15. 00		l ol			0		Ö	15. 00
16. 00		O			0		0	16. 00
17.00		o			0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		1			0		18. 00
19. 00	Fund balance at end of period per balance		-12, 648, 691			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Endownient Fund	PLAIIL	Fullu				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5. 00 6. 00			0					5. 00 6. 00
7. 00			0					7. 00
8. 00			0					8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)	o	_		0			10. 00
11.00	Subtotal (line 3 plus line 10)	O			0			11. 00
12.00	ROUNDI NG		0					12.00
13.00			0					13.00
14. 00			0					14. 00
15. 00			0					15. 00
16.00			0					16.00
17. 00	Total deductions (sum of lines 12 17)		O					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance				0			18. 00 19. 00
17.00	sheet (line 11 minus line 18)	"			U			17.00
	10 (1 11 110. 10)	1	· ·	1	- 1			

Peri od: Worksheet G-2 From 01/01/2017 To 12/31/2017 Parts I & II Date/Time Prepared: 5/19/2018 11:06 am

			'	0 12/01/2017	5/19/2018 11:	06 am
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		6, 278, 702	1	6, 278, 702	1. 00
2.00	SUBPROVI DER - I PF		C	I I	0	2. 00
3.00	SUBPROVI DER - I RF		C)	0	3. 00
4.00	SUBPROVI DER		_			4. 00
5.00	Swing bed - SNF		C)	0	5. 00
6.00	Swing bed - NF		C		0	6.00
7.00	SKILLED NURSING FACILITY		C		0	7.00
8.00	NURSING FACILITY		(0	8.00
9.00	OTHER LONG TERM CARE			'l I	-	9. 00 10. 00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		6, 278, 702		6, 278, 702	10.00
11. 00	INTENSIVE CARE UNIT		2, 437, 090		2, 437, 090	11. 00
12. 00	CORONARY CARE UNIT		2, 437, 090	1	2, 437, 090	12.00
13. 00	BURN INTENSIVE CARE UNIT				0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				O	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes	2, 437, 090)	2, 437, 090	16. 00
10.00	11-15)	11103	2, 107, 070		2, 107, 070	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		8, 715, 792		8, 715, 792	17. 00
18. 00	Ancillary services		35, 365, 853		121, 745, 851	18. 00
19.00	Outpatient services			o	0	19. 00
20.00	RURAL HEALTH CLINIC		C	o	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		C	o	0	21. 00
22. 00	HOME HEALTH AGENCY			0	0	22. 00
23.00	AMBULANCE SERVICES		C	o	0	23. 00
24.00	CMHC			0	0	24. 00
24. 10	CORF		C	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		C	0	0	25. 00
26.00	HOSPI CE		C	0	0	26. 00
27. 00	OTHER (SPECIFY)		C	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	44, 081, 645	86, 379, 998	130, 461, 643	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES			04 004 704		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			31, 231, 796		29. 00
30.00	ADD (SPECIFY)		C	I		30.00
31.00			C	1		31.00
32. 00 33. 00			C	I		32. 00 33. 00
34. 00		1	C			34. 00
35. 00			C			35. 00
36. 00	Total additions (sum of lines 30-35)		C	<u></u>		36.00
37. 00	DEDUCT (SPECIFY)		(J		37. 00
38. 00	DEBOOT (SI EOITT)					38. 00
39. 00						39. 00
40. 00			C			40.00
41. 00			C			41. 00
42. 00	Total deductions (sum of lines 37-41)			0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		31, 231, 796		43. 00
	to Wkst. G-3, line 4)	·				
		•		•		-

Heal th	Financial Systems MONROE H	IOSPI TAI	In lie	eu of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0183	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017		
			<u> </u>		
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	,		130, 461, 643	1. 00
2.00	Less contractual allowances and discounts on patients' acc	ounts		103, 429, 773	
3.00	Net patient revenues (line 1 minus line 2)			27, 031, 870	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		31, 231, 796	
5.00	Net income from service to patients (line 3 minus line 4)			-4, 199, 926	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			7, 570	7. 00
8.00	Revenues from telephone and other miscellaneous communicat	ion services		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
	Purchase di scounts			0	10. 00
	Rebates and refunds of expenses			0	11. 00
	Parking lot receipts			0	12. 00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			109, 022	
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to othe	r than patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			212	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
22 00	Covernmental appropriations			l	22 00

0 23.00

24. 01

24.02

25.00

26.00 3, 500 27. 00 3, 500 28. 00

23, 284

592, 510

732, 895

-3, 467, 031

297

-3, 470, 531 29. 00

23.00 Governmental appropriations

24. 02 OTHER-ELEC HEALTH RECORD

24. 01 OTHER INCOME/OTHER OPERATING REVENUE

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER NON-OPERATING EXPENSE

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

24. 00 OPTHER ANCILLARY

CALCIII		HOSPI TAL		u of Form CMS-2	2552-10
3. 1.2001	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0183	Period: From 01/01/2017 To 12/31/2017		pared:
		T: 11 V0/111		5/19/2018 11:	06 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			411, 932	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			333, 993	
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost	reporting period (see inst	rustions)	0 11. 56	2. 01 3. 00
4.00	Number of interns & residents (see instructions)	reporting period (see inst	.ructrons)	0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1.01	. columns 1 and	0.00	6.00
	1.01) (see instructions)		,	_	
7.00	Percentage of SSI recipient patient days to Medicare Part	0.00	7. 00		
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see ins	structions)		0.00	
9. 00 10. 00	Sum of lines 7 and 8	ans)		0. 00 0. 00	
11. 00	Allowable disproportionate share percentage (see instructi Disproportionate share adjustment (see instructions)	UIS)		0.00	
	Total prospective capital payments (see instructions)			745, 925	
.2.00	prospective supremi paymente (eee instructions)			7 107 720	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)	•		0	
2.00	Program inpatient ancillary capital cost (see instructions	5)		0	
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	
0.00	Trotal impatrent program capital cost (iffice of x iffice i)			O O	0.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	1.00
1.00	Program inpatient capital costs for extraordinary circums	cances (see instructions)		0	2. 00 3. 00
2.00				0	
2.00 3.00	Net program inpatient capital costs (line 1 minus line 2)			0.00	
2. 00 3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0.00	4. 00
2. 00 3. 00 4. 00 5. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	e instructions)		0	4. 00 5. 00
2. 00 3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see		(line 6)		4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)		(line 6)	0 0. 00	4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin	nary circumstances (line 2)	(line 6)	0 0. 00 0	4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordir Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level	nary circumstances (line 2) oplicable) co capital payments (line 8	less line 9)	0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordir Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as approximately contact the contact of the contact	nary circumstances (line 2) oplicable) co capital payments (line 8	less line 9)	0.00 0.00 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordir Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as application of Capital minimum payment level (Carryover of accumulated capital minimum payment level over	nary circumstances (line 2) oplicable) to capital payments (line 8 er capital payment (from pri	less line 9) or year	0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
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2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordir Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as application of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level over C	pary circumstances (line 2) pplicable) co capital payments (line 8 er capital payment (from pri payments (line 10 plus line the amount on this line	less line 9) or year ne 11)	0.00 0.00 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as application of capital minimum payment level of Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, er	pary circumstances (line 2) pplicable) co capital payments (line 8 er capital payment (from pri payments (line 10 plus line ter the amount on this line er capital payment for the 1	less line 9) or year ne 11)	0.00 0.00 0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordir Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicated to the comparison of capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	pary circumstances (line 2) pplicable) to capital payments (line 8 er capital payment (from pri payments (line 10 plus line ter the amount on this line er capital payment for the 1 instructions)	less line 9) or year ne 11)	0.00 0.00 0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00