payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0183 Worksheet S Peri od: From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm

PART I - COST	REPORT STATUS	
Provi der	1.[X]Electronically filed cost report	Date: 5/26/2019 Time: 12:54 pm
use only	2. [] Manually submitted cost report	
	3. [0] If this is an amended report enter the number of 4. [F] Medicare Utilization. Enter "F" for full or "L" $$	times the provider resubmitted this cost report for low.
Contractor use only	5. [1] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. [N] Initial Report for the first of	10. NPR Date: 11. Contractor's Vendor Code: 4 12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 01/01/2018 and ending 12/31/2018 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.

[X]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.

> HI LARY DOLBEE (Si aned) Officer or Administrator of Provider(s)

> > CF0 Title

(Dated when report is electronically signed.) Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-96, 409	2, 493	0	172, 823	1. 00
2.00	Subprovi der – 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	-96, 409	2, 493	0	172, 823	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. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4011 SOUTH MONROE MEDICAL PARK BLVD 1.00 PO Box: 1.00 State: IN County: MONROE 2.00 City: BLOOMINGTON Zip Code: 47403 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MONROE HOSPITAL 150183 14020 10/16/2006 N 3.00 Hospi tal Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital - Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17.10 17. 11 Hospital-Based (CORF) II 17.11 18.00 Renal Dialysis 18.00 19.00 Other 19.00 To: From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 20.00 12/31/2018 21.00 Type of Control (see instructions) 4 21.00 1.00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22 01 N Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost

23. 00	reporting period occurring on or after October 1. (so Does this hospital contain at least 100 but not more counted in accordance with 42 CFR 412.105)? Enter in yes or "N" for no. Which method is used to determine Medicaid days on libelow? In column 1, enter 1 if date of admission, 2 if date of discharge. Is the method of identifying the reporting period different from the method used in the reporting period? In column 2, enter "Y" for yes or		3 1	ų.		23. 00		
		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	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
		4.00	days	2.22	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	31	0	0	0	358	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4. Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
	,		<u> </u>			<u> </u>		<u>'</u>
MCRI F3:	2 - 15. 5. 166. 1							

ealth Financial Systems MOI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	NROE HO TA	Provi der Co	CN: 15-0183	Peri od: From 01/01/2018	Worksheet S-2 Part I	
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	LME	D: LOWE	To 12/31/2018	Date/Time Pre 5/26/2019 12:	pared 54 pm
	Y/N	IME	Direct GME	IME	Direct GME	
1.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	5.00	61. (
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care					3.03	61. (
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61. (
determining compliance with the 75% test. (see instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. (
21.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 11.06 Enter the amount of ACA §5503 award that is being						61. (
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
	Pro	ogram Name			Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00	61.
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00		61.
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				ried for which	0.00	62. (
your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	tions) Teachi ram. (s	ng Health Cen see instruction	ter (THC) int			62. (
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63. (
,	CO TITLE	S OF THE OUGHT	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Section FEOM of the ACA Page Vegs FTE Decidents in Me	nnrovi	for Sottings	1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor 4.00 Enter in column 1, if line 63 is yes, or your facilit	e June	30, 2010.	This base yea			64.
in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	-primar all nor non-pr columr	ry care nprovider imary care n 3 the ratio				

	beginning on or after July 1, 20	010					
66.00	Enter in column 1 the number of	unweighted non-primar	y care resident	0.00	0. 00	0. 000000	66.00
	FTEs attributable to rotations of	occurring in all nonpr	rovider settings.				
	Enter in column 2 the number of	unweighted non-primar	ry care resident				
	FTEs that trained in your hospit	al. Enter in column 3	the ratio of				
	(column 1 divided by (column 1 +	column 2)). (see ins	tructions)				
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs		(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			0.00	0.00	0. 000000	67. 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						

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods

Nonprovi der

Si te 1.00 Hospi tal

2.00

2))

3.00

	1. 00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	oprovi der? N			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			0	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 teac				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting	ng peri od.			
(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.				
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in			0	76. 00
recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o				
no. Column 2: Did this facility train residents in a new teaching program in accordance				
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is N				
indicate which program year began during this cost reporting period. (see instructions))			

4)). (see instructions)

complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as

appl i cabl e.

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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm 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

Name: PRIME HEALTHCARE SERVICES INC | Contractor's Name: NORIDIAN 141 OO Name: PRIME HEALTHCARE SERVICES INC. 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 148 00 N 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 Ν 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 161. 00 CMHC Ν Ν N 161. 00 161. 10 CORF Ν Ν Ν 161. 10 161. 11 CORF N Ν N 161. 11 1.00 Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?

Enter "Y" for yes or "N" for no. N 165.00 FTE/Campus CBSA Name County State | Zip Code 0 1.00 2.00 3.00 4.00 5.00 0.00166.00 166.00 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) 1 00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. Υ 167. 00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 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) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99 169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2018 12/31/2018 170.00

1. 00

Ν

2.00

0171.00

period respectively (mm/dd/yyyy)

1876 Medicare days in column 2. (see instructions)

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

	Financial Systems MONROE HO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0183	Period: From 01/01/2018 To 12/31/2018	wof Form CMS Worksheet S Part II Date/Time P 5/26/2019 1	-2 repared:
		Descr	pti on	Y/N	Y/N	
)	1. 00	3. 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	
	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 (EXCEP	PT CHILDRENS H	OSPI TALS)		1.00	
C	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 00
	Have changes occurred in the Medicare depreciation expense of	due to apprais	als made duri	ng the cost		23. 00
	reporting period? If yes, see instructions.					
	Were new leases and/or amendments to existing leases entered	d into during	this cost rep	orting period?		24. 00
	If yes, see instructions	the cost reser	ting ported?	If you coo		25 00
	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	ii yes, see		25. 00
	Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost renorti	na period? It	ves see		26. 00
	instructions.	_ 0000 1 opo1 t1		, 50, 000		20.00
1	Has the provider's capitalization policy changed during the	cost reportir	g period? If	yes, submit		27. 00
	copy.					
	Interest Expense					
	Were new Loans, mortgage agreements or Letters of credit ent	tered into dur	ing the cost	reporti ng		28. 00
	period? If yes, see instructions.	hl - (D-	L+ C			20.00
	Did the provider have a funded depreciation account and/or between a funded depreciation account? If you are instru		ebt Service Re	eserve Funa)		29. 00
	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		doht2 lf voc	500		30.00
	instructions.	iity with new	debt: 11 yes,	366		30.00
	Has debt been recalled before scheduled maturity without iss	suance of new	debt? If yes,	see		31.00
L	instructions.					
	Purchased Services					
	Have changes or new agreements occurred in patient care serv		d through cor	itractual		32. 00
	arrangements with suppliers of services? If yes, see instruction of Sec. 2135.2 appliers are the requirements of Sec. 2135.2 appliers.		a to compotit	ivo bidding2 lf		33. 00
	no, see instructions.	ireu pertainii	ig to competi	ive broating? IT		33.00
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an arm	rangement with	provi der-bas	sed physicians?		34.00
	If yes, see instructions.	3		7 7		
	If line 34 is yes, were there new agreements or amended exis		its with the p	rovi der-based		35. 00
	physicians during the cost reporting period? If yes, see ins	structions.				
				Y/N	Date	
l.	Home Office Costs			1. 00	2. 00	
	Were home office costs claimed on the cost report?			Υ		36.00
	If line 36 is yes, has a home office cost statement been pro	enared by the	home office?	Ϋ́		37. 00
	If yes, see instructions.	opai oa zy tiio		·		07.00
38. 00	If line 36 is yes, was the fiscal year end of the home offi	ice different	from that of	N		38. 00
-	the provider? If yes, enter in column 2 the fiscal year end	of the home o	ffi ce.			
	If line 36 is yes, did the provider render services to other	r chain compor	ents? If yes,	N		39. 00
1	see instructions.					
	If line 36 is yes, did the provider render services to the h	nome office?	ır yes, see	N		40. 00
	instructions.					
		1	00	2	00	
	Cost Donart Dranarar Contact Information			2.	-	
	JOST REPORT Preparer Contact Information					
(Cost Report Preparer Contact Information Enter the first name, last name and the title/position	JEFFREY		BROWN		41.00
41. 00		JEFFREY		BROWN		41.00
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	JEFFREY HOSPITAL MANAG	EMENT SERVICE			41. 00
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.		EMENT SERVICE		0FFL 0F .02**	

Heal th F	inancial Systems	MONROE H	IOSPI TA	AL		In Lie	eu of Form CMS-	2552-10
HOSPI TAL	L AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Р	rovider CCN:		Peri od:	Worksheet S-2	2
						From 01/01/2018 To 12/31/2018	Date/Time Pro	epared:
						12, 01, 2010	5/26/2019 12:	
				3.00	1			
Co	ost Report Preparer Contact Information							
	Enter the first name, last name and the t		CE0					41. 00
h	neld by the cost report preparer in colum	ıns 1, 2, and 3,						
r	respecti vel y.							
42. 00 E	Enter the employer/company name of the co	st report						42. 00
	preparer.							
	Enter the telephone number and email addr							43. 00
r	report preparer in columns 1 and 2, respe	cti vel y.						

						'	0 12/01/2010	5/26/2019 12:	54 pm
	·							I/P Days / O/P	
								Visits / Trips	
	Component	Worksheet A	No.	of B	eds	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				İ			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	0	8. 00
9.00	CORONARY CARE UNIT	32. 00			0	C	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00			0	C	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00			0	C	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)				İ				12. 00
13.00	NURSERY	43. 00						0	13. 00
14.00	Total (see instructions)				32	11, 680	0.00	0	14. 00
15.00	CAH visits							0	15. 00
16.00	SUBPROVIDER - IPF	40. 00			0	C)	0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00			O	C)	0	17. 00
18. 00	SUBPROVI DER								18. 00
19.00	SKILLED NURSING FACILITY	44. 00			O	C)	0	19. 00
20.00	NURSING FACILITY	45. 00			O	C)	0	20. 00
21. 00	OTHER LONG TERM CARE	46. 00			O	C)		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			o	C)		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
25. 11	CMHC - CORF	99. 11						0	25. 11
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	Ambulance Trips							Ĭ	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	1		32. 00
32. 00	Total ancillary labor & delivery room				٦	C			32. 00
52.01	outpatient days (see instructions)								32.01
33. 00	LTCH non-covered days								33. 00
	LTCH site neutral days and discharges								33. 01
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1			- 1		T.	1	

Provider CCN: 15-0183

						5/26/2019 12:	54 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	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	2, 279	26	3, 209		10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	2,277	20	0, 207			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	o	358				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	o				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	o	C			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		o	C			6.00
7.00	Total Adults and Peds. (exclude observation	2, 279	26	3, 209			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	199	5	1, 026			8. 00
9.00	CORONARY CARE UNIT	0	0	C			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0	C			10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	C			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		0	C			13. 00
14.00	Total (see instructions)	2, 478	31	4, 235	0.00	163. 55	14. 00
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVI DER - I PF	0	0	C	0.00		16. 00
17. 00	SUBPROVI DER - I RF	0	0	C	0.00	0.00	
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	C		l e	19. 00
20. 00	NURSING FACILITY		0	C	0.00		20. 00
21. 00	OTHER LONG TERM CARE			C		l e	21. 00
22. 00	HOME HEALTH AGENCY	0	0	C	0.00		22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	l e	23. 00
24. 00	HOSPI CE	0	0	C		0.00	24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC	0	0	C			25. 00
25. 10	CMHC - CORF	0	0	C		l e	25. 10
25. 11	CMHC - CORF	0	0	C		l	25. 11
26. 00	RURAL HEALTH CLINIC	0	0	C		l	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00		26. 25
27. 00	Total (sum of lines 14-26)				0.00	163. 55	•
28. 00	Observation Bed Days	9	0	C			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF	9					31.00
32.00	Labor & delivery days (see instructions)	0	0	C			32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	o					33. 00
	LTCH non-covered days LTCH si te neutral days and di scharges	0					33.00
JJ. UI	LION SI LE HEULT di days allu di schai yes	٩			I	I	J 33. U I

						5/26/2019 12:	54 pm
	·	Full Time		Di sc	harges		
		Equi val ents					
	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			0 638	13	1, 148	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)						0.00
2.00	HMO and other (see instructions)			50			2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				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 beds) (see instructions)						7. 00
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		0 638	13	1, 148	14. 00
15. 00	CAH visits	0.00		030	13	1, 140	15. 00
16. 00	SUBPROVIDER - I PF	0. 00		0	0	0	16. 00
17. 00	SUBPROVI DER - I RF	0.00					17. 00
18. 00	SUBPROVI DER	0.00		Y Y		0	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				O	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)	0.00					24. 10
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
25. 11	CMHC - CORF	0. 00					25. 11
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 Trips						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
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	•	•		•		'	

| Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0183

					Ť	o 12/31/2018	Date/Time Pre	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	5/26/2019 12: Average Hourly	54 piii
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from Wkst. A-6)	$(col.2 \pm col.$ 3)	Salaries in col. 4	col . 5)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	11, 113, 656	ol	11, 113, 656	374, 210. 00	29. 70	1.00
	instructions)							
2. 00	Non-physician anesthetist Part A		C	0	0	0. 00	0.00	2. 00
3.00	Non-physician anesthetist Part		C	О	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		C	0	0	0.00	0. 00	4. 00
	Admi ni strati ve				0			
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C	1	0	0. 00 0. 00	l .	1
3.00	Physician-Part B		C		0	0.00	0.00	3.00
6.00	Non-physician-Part B for		C	0	0	0.00	0.00	6. 00
	hospital-based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		C	o	0	0. 00	0.00	7. 01
	residents (in an approved							
8. 00	programs) Home office and/or related		C	0	0	0.00	0. 00	8. 00
	organization personnel		_					
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	104, 660	0	0 104, 660	0. 00 2, 115. 00		1
	instructions)				,	,		
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		218, 528	ol	218, 528	6, 081. 00	35. 94	11. 00
	Care							
12. 00	Contract labor: Top level management and other		60, 000	0	60, 000	480. 00	125. 00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		C	0	0	0.00	0.00	13. 00
	A - Administrative		, and a second		· ·			
14. 00	Home office and/or related organization salaries and		C	0	0	0.00	0.00	14. 00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		676, 126	1	676, 126 0	20, 850. 00 0. 00	l .	14. 01 14. 02
15. 00	Home office: Physician Part A		C		0	0.00		15. 00
16. 00	- Administrative Home office and Contract		C	0	0	0.00	0.00	16. 00
10.00	Physicians Part A - Teaching			٩		0.00	0.00	10.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		2, 730, 150	l ol	2, 730, 150		T	17. 00
	instructions)		2,,00,.00		2,,00,100			
18. 00	Wage-related costs (other) (see instructions)		C	0	0			18. 00
19. 00	Excluded areas		25, 997	l I	25, 997			19. 00
20. 00	Non-physician anesthetist Part A		C	0	0			20. 00
21. 00	Non-physician anesthetist Part		C	О	0			21. 00
22. 00	B Physician Part A -		C	o	0			22. 00
	Admi ni strati ve				_			
22. 01 23. 00	Physician Part A - Teaching Physician Part B		C	0	0			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		C	o	0			24. 00
25. 00	Interns & residents (in an		C	0	0			25. 00
25. 50	approved program) Home office wage-related		C	О	0			25. 50
25. 51	(core) Related organization			0	0			25. 51
۷۵. ۵۱	wage-related (core)		C	1 4	U			20.01
25. 52	Home office: Physician Part A - Administrative -		C	0	0			25. 52
	wage-related (core)							
25. 53	Home office & Contract		C	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	176, 652	O	176, 652	4, 900. 00	36. 05	26. 00
27. 00	Administrative & General	5. 00						27. 00
		'						

					T	o 12/31/2018	Date/Time Prep 5/26/2019 12:	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number		on of Salaries	,		Wage (col. 4 ÷	
		Number	kepoi teu	(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4	COI . 3)	
		1, 00	2. 00	3.00	4.00	5, 00	6. 00	
28. 00	Administrative & General under		0	0	0	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	301, 472	0	301, 472	11, 607. 00	25. 97	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0. 00	31.00
32.00	Housekeepi ng	9. 00	278, 778	0	278, 778	21, 640. 00	12. 88	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	286, 434	0	286, 434	19, 908. 00	14. 39	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	1, 059, 148	0	1, 059, 148	13, 188. 00	80. 31	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	142, 109	0	142, 109	7, 419. 00	19. 15	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION In Lieu of Form CMS-2552-10 MONROE HOSPITAL Provi der CCN: 15-0183 Peri od: Worksheet S-3

							rom 01/01/2018 o 12/31/2018		
			Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
			Line Number		on of Salaries	,		Wage (col. 4 ÷	
				,	(from	(col.2 ± col.	Salaries in	col . 5)	
					Worksheet A-6)	3)	col. 4	,	
			1.00	2.00	3.00	4.00	5. 00	6. 00	
_		PART III - HOSPITAL WAGE INDEX	SUMMARY						
	1.00	Net salaries (see		11, 113, 656	0	11, 113, 656	374, 210. 00	29. 70	1.00
		instructions)							
	2.00	Excluded area salaries (see		104, 660	0	104, 660	2, 115. 00	49. 48	2.00
		instructions)							
	3.00	Subtotal salaries (line 1		11, 008, 996	0	11, 008, 996	372, 095. 00	29. 59	3.00
		minus line 2)							
	4.00	Subtotal other wages & related		954, 654	0	954, 654	27, 411. 00	34. 83	4. 00
		costs (see inst.)							
	5.00	Subtotal wage-related costs		2, 730, 150	0	2, 730, 150	0.00	24. 80	5.00
		(see inst.)							
	6.00	Total (sum of lines 3 thru 5)		14, 693, 800	l .	14, 693, 800			
	7. 00	Total overhead cost (see		3, 743, 006	0	3, 743, 006	129, 044. 00	29. 01	7. 00

instructions)

Health Financial Systems	MONROE HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0183	Peri od:	Worksheet S-3
		From 01/01/2018	
			D 1 (T) D 1

	To 12/31/20	18 Date/Time Pre 5/26/2019 12:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	87, 785	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	<u>'</u>	
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Heal th Insurance (Purchased)	1, 847, 536	
9. 00	Prescription Drug Plan	0	
10.00	Dental, Hearing and Vision Plan	0	10.00
	Life Insurance (If employee is owner or beneficiary)	10, 711	
	Accident Insurance (If employee is owner or beneficiary)	0	1
		0	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	0	
		0	
10.00	Non cumulative portion)		10.00
	TAXES		
17. 00	FICA-Employers Portion Only	810, 115	17. 00
	Medicare Taxes - Employers Portion Only	0	1
	Unempl oyment Insurance	0	19. 00
	State or Federal Unemployment Taxes	0	
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	ee 0	21. 00
200	instructions))	,	200
22.00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	
	Total Wage Related cost (Sum of lines 1 -23)	2, 756, 147	
	Part B - Other than Core Related Cost	_,,,	1
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
	1	,	

Health Financial Systems	MONROE HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0183	From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared:

		To 12/31/2018	Date/Time Prep 5/26/2019 12:	
	Cost Center Description	Contract Labor	Benefit Cost	54 piii
		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	218, 528	2, 756, 147	1. 00
2.00	Hospi tal	218, 528	2, 730, 150	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovider - (0ther)	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
16. 11	Hospi tal -Based-CMHC 11	0	0	16. 11
17. 00	Renal Dialysis	0	0	17. 00
18. 00	Other	0	25, 997	18. 00

1.00 C MM 2.00 N 3.00 I 5.00 I 6.00 M 7.00 M 8.00 D C C C 9.00 N	Incompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 cledicaid (see instructions for each line) Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental line 4 is no, then enter DSH and/or supplemental payments Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid programs zero then enter zero)	ental payment	ne 202 column	Peri od: From 01/01/2018 To 12/31/2018		pared: 54 pm					
1.00 C MR 2.00 N 3.00 D 4.00 I 5.00 I 6.00 M 7.00 M 8.00 D < 9.00 N 10.00 S 11.00 S	Cost to charge ratio (Worksheet C, Part I line 202 column 3 colledicaid (see instructions for each line) Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments for Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	ental payment		To 12/31/2018	Date/Time Prep 5/26/2019 12: 5 1.00 0.229693	54 pm					
1.00 C MR 2.00 N 3.00 D 4.00 I 5.00 I 6.00 M 7.00 M 8.00 D < 9.00 N 10.00 S 11.00 S	Cost to charge ratio (Worksheet C, Part I line 202 column 3 colledicaid (see instructions for each line) Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments for Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	ental payment		n 8)	0. 229693	1.00					
1.00 C MR 2.00 N 3.00 D 4.00 I 5.00 I 6.00 M 7.00 M 8.00 D < 9.00 N 10.00 S 11.00 S	Cost to charge ratio (Worksheet C, Part I line 202 column 3 colledicaid (see instructions for each line) Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments for Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	ental payment		n 8)		1.00					
2.00 N 3.00 D 4.00 I 5.00 I 6.00 M 7.00 M 8.00 D < 0 N 10.00 S 11.00 S	Medicaid (see instructions for each line) Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental fine 4 is no, then enter DSH and/or supplemental payments Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	ental payment		1 8)		1.00					
3.00 D 4.00 I 5.00 I 6.00 M 7.00 M 8.00 C CI 9.00 N 10.00 S	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or suppleme If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program		s from Medica		1, 906, 905	4					
4.00 I 5.00 I 6.00 M 7.00 M 8.00 D < CI 9.00 N 10.00 S	If line 3 is yes, does line 2 include all DSH and/or suppleme If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program		s from Medica			1					
5. 00 I 6. 00 M 7. 00 M 8. 00 D < CI 9. 00 N 10. 00 S 11. 00 S	fline 4 is no, then enter DSH and/or supplemental payments Medicaid charges Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program		s from Medica			3. 00					
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7. 00 M 8. 00 D < CI 9. 00 N 10. 00 S 11. 00 S	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program		a		0 17, 531, 504						
8.00 D CI 9.00 N 10.00 S 11.00 S	Difference between net revenue and costs for Medicaid program				4, 026, 864	1					
9. 00 N 10. 00 S 11. 00 S		n (line 7 min	us sum of li	nes 2 and 5; if	2, 119, 959	1					
9. 00 N 10. 00 S 11. 00 S											
10. 00 S 11. 00 S	Children's Health Insurance Program (CHIP) (see instructions	for each lin	e)		_						
11. 00 S	Net revenue from stand-alone CHIP				0						
4	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0						
	Difference between net revenue and costs for stand-alone CHIF	Cline 11 mi	nus line 9	f < zero then							
е	enter zero)] .2.00					
	ther state or local government indigent care program (see in										
	Net revenue from state or local indigent care program (Not in				0						
	Charges for patients covered under state or local indigent ca	ire program (Not included	in lines 6 or	0	14. 00					
	10) State or local indigent care program cost (line 1 times line	14)			o	15. 00					
	Difference between net revenue and costs for state or local i		program (li	ne 15 minus line		1					
	13; if < zero then enter zero)										
	crants, donations and total unreimbursed cost for Medicaid, Constructions for each line)	HIP and stat	e/local indiç	gent care program	ns (see						
	Private grants, donations, or endowment income restricted to	fundi ng char	ity care		0	17. 00					
	Government grants, appropriations or transfers for support of				0						
	Total unreimbursed cost for Medicaid , CHIP and state and loc	cal indigent	care programs	s (sum of lines	2, 119, 959	19. 00					
	3, 12 and 16)		Uni nsured	Insured	Total (col. 1						
			patients	patients	+ col . 2)						
			1.00	2. 00	3. 00						
	Incompensated Care (see instructions for each line)			ool 0 == ((0.40)						
	Charity care charges and uninsured discounts for the entire f (see instructions)	facility	56, 58	3, 556	60, 136	20.00					
	Cost of patients approved for charity care and uninsured disc nstructions)	counts (see	12, 9	96 3, 556	16, 552	21. 00					
22. 00 P	Payments received from patients for amounts previously writte charity care	en off as	9, 6	17 0	9, 617	22. 00					
	Cost of charity care (line 21 minus line 22)		3, 3	79 3, 556	6, 935	23. 00					
					1.00						
24. 00 D	Does the amount on line 20 column 2, include charges for pati	ent days bev	ond a Length	of stay limit	N N	24. 00					
i	mposed on patients covered by Medicaid or other indigent car fline 24 is yes, enter the charges for patient days beyond	e program?		•	0						
s	stay limit	•		3.							
1	Total bad debt expense for the entire hospital complex (see i				7, 388, 128	1					
	Medicare reimbursable bad debts for the entire hospital compl				7, 296						
1	Medicare allowable bad debts for the entire hospital complex	(see instruc	tions)		11, 225	1					
1	Non-Medicare bad debt expense (see instructions)	vnonce (cos	instructions	,	7, 376, 903	1					
		exhelipe (266	instructions,)							
	2001 of ancompensation care (fine 20 continue of prior fille 27)			Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 1,698,352 29.00 1,705,287 30.00							

Cost Center Description		Financial Systems	MONROE HOSE		ON 45 0400 5		u of Form CMS-2	2552-10
Cost Center Description	RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co			Worksheet A	
Cost Center Description						o 12/31/2018		
Pare Pare		Cost Conton Decemintion	Calarias	0+605	Total (asl 1	Dool agai fi agti		54 pm
COMMON SERVICE COST CENTERS		cost center bescription	Sararres	other				
					1 001. 2)	0113 (000 71 0)		
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2.00 000000 INDIFICE CONTROL EDUTY 172.652 2.843.073 10.9000 1	1 00			4 (10 4/5	4 (10 4/5	. (4 110	4 (02 577	1 00
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4.00 GOLDO INPETITE IS DEPARTEMENT 1.76, 667 2, 183, 037 10 7, 817, 727 257, 747 257, 747 270, 341 270 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731 247 271, 731		1		0		0		
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Health Financial Systems	MONROE HOS				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	:N: 15-0183	Peri od: From 01/01/2018	Worksheet A	
				To 12/31/2018	Date/Time Pre	nared:
				10 12/31/2010	5/26/2019 12:	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cati	Reclassi fied	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
99. 11 09911 CORF	0	0		0		99. 11
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUISITION	0	0		0 0		105. 00
106. 00 10600 HEART ACQUISITION	0	0		0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	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	_	0		0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	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)	11, 008, 996	22, 174, 893	33, 183, 8	39 2, 125	33, 186, 014	118.00
NONREI MBURSABLE COST CENTERS					0	100.00
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 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	104 ((0)	24 220	120 0	0 2 125		194. 00
194. 01 07951 PUBLI C RELATI ONS	104, 660	34, 338	138, 99		136, 873	
194.02 07952 MOB 200.00 TOTAL (SUM OF LINES 118 through 199)	11 112 (5)	22 200 221	22 222 0	0 37 0		194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	11, 113, 656	22, 209, 231	33, 322, 8	0	33, 322, 887	200.00

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/26/2019 12:54 pm

				5/26/2019 12:	54 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	OFNEDAL CEDILLOF COCT OFNEDO	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	10.071	1 (02 040	J	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	10, 371 14, 876			1. 00 2. 00
3. 00	00300 OTHER CAP REL COSTS	14,870		1	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			l .	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	321, 886		•	5.00
6. 00	00600 MAINTENANCE & REPAIRS	321,880	280, 341		6.00
7. 00	00700 OPERATION OF PLANT	-44, 780		•	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	-44, 780			8.00
9. 00	00900 HOUSEKEEPI NG				9. 00
10. 00	01000 DI ETARY	0		1	10.00
11. 00	01100 CAFETERI A	-112, 444	l .	l .	11.00
13. 00	01300 NURSING ADMINISTRATION	-55, 302			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-55, 302		1	14. 00
15. 00	01500 PHARMACY			l .	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-187		l .	16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-107	201,003		10.00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 369, 360		30.00
31. 00	03100 I NTENSI VE CARE UNI T			•	31.00
32. 00	03200 CORONARY CARE UNIT			l .	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		_	l .	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00	04000 SUBPROVIDER - I PF				40.00
41. 00	04100 SUBPROVIDER - IRF				41.00
43. 00	04300 NURSERY				43.00
44. 00	04400 SKILLED NURSING FACILITY		0		44.00
45. 00	04500 NURSING FACILITY			l .	45. 00
46. 00	04600 OTHER LONG TERM CARE			l .	46. 00
40.00	ANCILLARY SERVICE COST CENTERS	0	0		40.00
50. 00	05000 OPERATING ROOM	-688, 070	1, 564, 004		50.00
51. 00	05100 RECOVERY ROOM	000,070			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM			l .	52.00
53. 00	05300 ANESTHESI OLOGY				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-30, 000	1, 204, 107		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	-30,000		1	55.00
56. 00	05600 RADI OI SOTOPE		_		56.00
57. 00	05700 CT SCAN				57.00
		0	0		1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1 200	_		59.00
60.00	06000 LABORATORY	-1, 300	1, 114, 268		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	_		64.00
65. 00	06500 RESPI RATORY THERAPY	0		•	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		l .	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00	1	0	0		68. 00
69. 00		-68, 936	233, 061		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	_, -,,	l .	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		•	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	809, 016	•	73. 00
74. 00	07400 RENAL DIALYSIS	0	0		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	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				
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	-1, 078, 705	1, 284, 033		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				1
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	0		96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00	09900 CMHC	0	0		99. 00
99. 10	09910 CORF	0	0		99. 10
99. 11	09911 CORF	0	0		99. 11
100.00	10000 & SERVICES-NOT APPRVD PRGM	0	0		100. 00

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

			5/26/2019	12: 54 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
101.00 10100 HOME HEALTH AGENCY	0	0		101. 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 LI VER ACQUI SI TI ON	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 732, 591	31, 453, 423		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 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 00
194. 01 07951 PUBLI C RELATI ONS	0	136, 873		194. 01
194. 02 07952 MOB	0	0		194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 732, 591	31, 590, 296		200. 00

| Period: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/26/2019 12:54 pm

						5/26/2019 12	2:54 pm
		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	289, 605			1. 00
2.00		0.00	0	0			2. 00
3.00		0.00	O	0			3. 00
	TOTALS			289, 605			
	B - RENT AND LEASE-EQUIPMENT	·					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	156, 499			1.00
2.00		0.00	ol	0			2.00
3.00		0.00	o	0			3. 00
4.00		0.00	0	0			4. 00
5. 00		0.00	0	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
0.00	TOTALS — — — —		— — ў	156, 499			0.00
	C - UTILITIES		<u> </u>	130, 477			
1.00	OPERATION OF PLANT	7. 00	0	573, 387			1.00
2.00	OF ERATION OF TEAM	0.00	o	0			2. 00
3.00		0.00	o	0			3. 00
3.00	TOTALS — — — —	— — 0.00		573, 387			3.00
	D - LAUNDRY EXPENSE		U _I	373, 307			_
1. 00	LAUNDRY & LINEN SERVICE	8. 00	0	78, 532			1.00
1.00	TOTALS						1.00
	E - IMPLANTS AND PROSTHESIS		U	78, 532			
1 00		72.00	O	040 157			1 00
1. 00	IMPL. DEV. CHARGED TO	72. 00	ol .	849, 157			1. 00
	PATI ENTS	+					
	F - EQUIPMENT INTEREST		υĮ	849, 157			
1 00		2 00	ما	22.04/			1 00
1. 00	CAP REL COSTS-MVBLE EQUIP TOTALS			<u>23, 846</u>			1. 00
			U	23, 846			_
4 00	G - OPERATING INTEREST	F 00		004 (47			4 00
1.00	ADMI NI STRATI VE & GENERAL			201, 647			1. 00
	TOTALS		U	201, 647			
4 00	H - REPAIR AND MAINTENANCE	(00		000 044			4 00
1.00	MAINTENANCE & REPAIRS	6.00	0	280, 341			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
5.00		0.00	0	0			5. 00
6.00		0.00	0	0			6. 00
7.00		0. 00	0	0			7. 00
8.00		0. 00	0	0			8. 00
9.00		0.00	0	0			9. 00
10. 00		0.00	0	0			10. 00
11. 00		0.00	0_	0			11. 00
	TOTALS		0	280, 341			
500.00	Grand Total: Increases		0	2, 453, 014			500.00

		Decreases				372072017 12	T pin
	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	7.00	0.00	7.00	101.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	157, 883	10		1.00
2. 00	MEDICAL RECORDS & LIBRARY	16.00	o	17, 292	0		2. 00
3. 00	WOUND CARE	76. 98	o	114, 430	o		3. 00
0.00	TOTALS		— — 	289, 605	— — - -		0.00
	B - RENT AND LEASE-EQUIPMENT		<u> </u>	207, 000			
1.00	ADULTS & PEDIATRICS	30, 00	0	22, 820	10		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	5, 102	10		2.00
3. 00	OPERATING ROOM	50.00	Ö	10, 529	0		3. 00
4. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	96, 464	0		4. 00
5. 00	RESPIRATORY THERAPY	65. 00	0	13, 663	0		5. 00
6. 00	WOUND CARE	76. 98		1, 854	0		6.00
7. 00	EMERGENCY	91. 00	0	3, 942	0		7. 00
8.00			-1		٦		
8.00	PUBLIC RELATIONS	194.01	0	2, 125	0		8. 00
	TOTALS		U	156, 499			-
4 00	C - UTILITIES	F 00		F/F 00F			4 00
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	565, 805	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	1, 155	0		2. 00
3.00	WOUND CARE	<u>76.</u> 98		6, 427	0		3. 00
	TOTALS		0	573, 387			_
	D - LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	•	7 <u>8, 5</u> 32	0		1. 00
	TOTALS		0	78, 532			_
	E - IMPLANTS AND PROSTHESIS						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	849, 157	0		1. 00
	PATI ENTS	+	+	+			
	TOTALS		0	849, 157			_
	F - EQUIPMENT INTEREST						_
1.00	CAP REL COSTS-BLDG & FIXT	1.00	•_	23, 846	11		1. 00
	TOTALS		0	23, 846			_
	G - OPERATING INTEREST						
1. 00	CAP REL COSTS-BLDG & FIXT	1.00		201, 647	13		1. 00
	TOTALS			201, 647			_
	H - REPAIR AND MAINTENANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 235	0		1. 00
2.00	HOUSEKEEPI NG	9. 00	0	533	0		2. 00
3.00	DI ETARY	10.00	0	957	0		3. 00
4.00	MEDICAL RECORDS & LIBRARY	16. 00	0	85	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	O	881	0		5. 00
6.00	OPERATING ROOM	50.00	o	36, 055	0		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	755	О		7. 00
8.00	LABORATORY	60.00	o	3, 851	o		8. 00
9. 00	WOUND CARE	76. 98	O	2, 587	0		9. 00
10.00	EMERGENCY	91.00	O	1, 485	0		10.00
11. 00	OPERATION OF PLANT	7.00	O	229, 917	ol		11.00
	TOTALS			280, 341			1
500.00	Grand Total: Decreases		0	2, 453, 014			500.00
		!	-1		ļ		

					To 12/31/2018		
				Acqui si ti ons		072072017 12.	от ріп
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 300, 000	0	(0	0	1.00
2.00	Land Improvements	0	0	(0	0	2.00
3.00	Buildings and Fixtures	0	8, 000, 000	(0 8, 000, 000	l	3. 00
4.00	Building Improvements	9, 537, 884	0		0	8, 974, 405	4. 00
5.00	Fi xed Equipment	8, 440, 000	967, 075		0 967, 075	0	5. 00
6.00	Movable Equipment	908, 029	22, 249		0 22, 249	0	6. 00
7. 00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	20, 185, 913	8, 989, 324		0 8, 989, 324		8. 00
9.00	Reconciling Items	116, 389	0	(0	110, 517	9. 00
10.00	Total (line 8 minus line 9)	20, 069, 524	8, 989, 324	(0 8, 989, 324	8, 863, 888	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	8, 000, 000	0				3. 00
4.00	Building Improvements	563, 479	0				4. 00
5.00	Fixed Equipment	9, 407, 075	0				5. 00
6.00	Movable Equipment	930, 278	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	20, 200, 832	0				8. 00
9.00	Reconciling Items	5, 872	0				9. 00
10.00	Total (line 8 minus line 9)	20, 194, 960	0				10.00

Heal th	Financial Systems	MONROE HO	SPI TAL		In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0183	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018		pared:
					12, 31, 2313	5/26/2019 12:	54 pm
			Sl	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	40.00	44.00	instructions)		
	DART II. DECONOLILIATION OF AMOUNTS FROM WORK	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 & FIXT	4, 618, 465	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 618, 465	0		0 0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	Other 7	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	SHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	4, 618, 465				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3. 00	Total (sum of lines 1-2)		4, 618, 465				3. 00

Heal th	n Financial Systems	MONROE HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der C		Period: From 01/01/2018 To 12/31/2018		
		COME	PUTATION OF RAT	TI 0S	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	8, 557, 607	0	8, 557, 60	7 0. 476357	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 407, 075	0	9, 407, 07	5 0. 523643	0	2. 00
3.00	Total (sum of lines 1-2)	17, 964, 682		17, 964, 68			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FLXT	INTERS	0		0 4, 625, 893	289, 605	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 14, 876		2. 00
3.00	Total (sum of lines 1-2)	0	Ö		0 4, 640, 769		3. 00
			Sl	JMMARY OF CAPI		·	
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12.00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	-20, 903	0	-201, 64	7 0	4, 692, 948	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	23, 846			0 0	195, 221	2. 00
3.00	Total (sum of lines 1-2)	2, 943		1	-		3. 00
		•	'				

Provider CCN: 15-0183

					To 12/31/2018	Date/Time Prep 5/26/2019 12:5	
				Expense Classification o	n Worksheet A	3/20/2017 12.	эт рііі
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
00	COSTS-BLDG & FIXT (chapter 2)		· ·	STATE OF THE BEBUILDING			00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	226	CAP REL COSTS-BLDG & FIXT	1.00	11	3. 00
3.00	(chapter 2)		-230	CAL REE COSTS-BEDG & TTXT	1.00	''	3.00
4.00	Trade, quantity, and time		0		0.00	o	4.00
Г 00	di scounts (chapter 8)		0		0.00		Г 00
5. 00	Refunds and rebates of expenses (chapter 8)		U		0.00	0	5. 00
6.00	Rental of provider space by		0		0.00	О	6.00
7 00	suppliers (chapter 8)		7 .0.	00-01-1011 05 01 111-	7.00		7 00
7. 00	Telephone services (pay stations excluded) (chapter	A	- / , 434	OPERATION OF PLANT	7. 00	0	7. 00
	21)						
8.00	Television and radio service	A	-13, 315	ADMINISTRATIVE & GENERAL	5. 00	o	8. 00
0.00	(chapter 21)		0		0.00		0 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-1, 946, 313		0.00	0	9. 00 10. 00
10.00	adjustment	7.02	1, 710, 010			Ĭ	10.00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	501, 649			0	12. 00
12.00	transactions (chapter 10)	A-0-1	301, 049				12.00
13.00	Laundry and linen service		0		0.00	О	13.00
14.00	Cafeteria-employees and guests		-112, 444	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	О	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
17.00	patients		Ü		0.00	٥	17.00
18.00	Sale of medical records and	В	-187	MEDICAL RECORDS & LIBRARY	16. 00	О	18.00
10.00	abstracts		0		0.00		10.00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20. 00	Vendi ng machi nes		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	О	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
20.00	therapy costs in excess of	7, 0, 0	0	RESTRICTION THE TOTAL	00.00		20.00
0	limitation (chapter 14)			DINGLON. TUEDADY			04.5-
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		Ω	CAP REL COSTS-BLDG & FIXT	1.00	n	26. 00
	COSTS-BLDG & FLXT						
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		0	Jose Jones Boroted	0.00	О	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
, ,	instructions)		0		30.00		/ /
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	О	32. 00
00	Depreciation and Interest		a= - ·	ADMINI CTRATIVE & CONTROL	_		00.5
33. 00	RECRUI TI NG	A	-22, 118	ADMINISTRATIVE & GENERAL	5.00	0	33. 00

Heal th	Health Financial Systems MONROE			OSPI TAL	eu of Form CMS-2	2552-10	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0183	Peri od:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018		
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cook Cooker Dooreitstier	D:- (01- (2)	A	C+ C+	1: "	WI+ A 7 D-6	
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
	T	1. 00	2.00	3. 00	4. 00	5. 00	
33. 01	CONTRI BUTI ONS	A	-527	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	LAB	В	-96	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	LOBBYING	A	-2, 120	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	MARKETI NG	A	-79, 547	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	AMORTIZATION EXPENSE LYONS	A	-32,000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
	CHARTS						
33. 06	LATE FEES	l A	-17, 903	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
50.00	TOTAL (sum of lines 1 thru 49)		-1, 732, 591				50.00
	(Transfer to Worksheet A,		,				
	(11 000)	1			1		

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

 A. Costs if cost, including applicable overhead, can be determined.

 B. Amount Received if cost cannot be determined.

column 6, line 200.)

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

OFFICE COSTS

Provider CCN: 15-0183

Worksheet A-8-1 From 01/01/2018

				To 12/31/2018	Date/Time Pre 5/26/2019 12:	
	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 ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	PHSI CAP COST - BLDG	7, 428	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PHSI CAP INTEREST - BLDG	3, 179	0	2.00
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	PHSI CAP COST - EQUIP	14, 876	0	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	PHSI NON-CAPITAL OTHER	1, 168, 627	0	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	PHSI NON-CAPITAL INTEREST	15, 981	0	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	936, 251	4. 02
4.03	5. 00	ADMINISTRATIVE & GENERAL	PATIENT ACCOUNTING	426, 393	161, 238	4.03
4.04	7. 00	OPERATION OF PLANT	BIO MED	192, 573	229, 919	4.04
5.00	TOTALS (sum of lines 1-4).			1, 829, 057	1, 327, 408	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
4				-l A I	/ !!	

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 PRIME HLTHCARE 100.00	6. 00
7.00	В	0.00 PRIME 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 PRIME 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

Heal th	Financial Syste	ems			MONROE HOSP	IIAL			In Lie	u of Form CM	S-2552-10
STATEME OFFICE	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-0183	Peri od: From 01/01/2018	Worksheet A	-8-1
									To 12/31/2018	Date/Time P 5/26/2019 1	
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUST	MENTS REQ	UIRED AS A RE	SULT OF TRA	NSACTI ONS	WI TH	RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:									
1.00	7, 428	9									1. 00
2.00	3, 179	11									2. 00
3.00	14, 876	9									3. 00
4.00	1, 168, 627	0									4. 00
4.01	15, 981	0									4. 01
4.02	-936, 251	0									4. 02
4.03	265, 155	0									4. 03

501, 649 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

4.04

5 00

nas i	iot been posted to worksheet A,	cordinas i diazor 2, the amount arrowable should be mareated in cordina 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	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 raimhursamant undar titla XVIII

i ei ilibui	Terlibur Seiliert Under titte XVIII.								
6.00	HOME OFFICE	6.00							
7.00	HOME OFFICE	7.00							
8.00	HOME OFFICE	8.00							
9.00	HOME OFFICE	9.00							
10.00	HOME OFFICE	10.00							
100.00		100.00							

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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

4.04

5.00

-37, 346

| Peri od: | Worksheet A-8-2 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: | From 01/01/2018 | Date/Time Prepared: | From 01/2018 | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time

								10 12/31/2018	5/26/2019 12:	
	Wkst. A Line #		Cost	Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	J4 pili
	mkst. // Line #		0031	I denti fi er	Remuneration	Component	Component	ROE AMOUNT	ider Component	
					Tromarior a cr on	oomponone	ooportorre		Hours	
	1. 00			2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 00	DR.	Α		24, 000					1. 00
2. 00	13. 00	DR.	В		55, 302	55, 302	C	171, 400	o	2. 00
3. 00	50. 00	DR.	С		688, 070				o	3. 00
4.00	54. 00	DR.	D		30, 000			0	o	4. 00
5. 00	60. 00	DR.	Ε		1, 300	1, 300	C	ol o	ol	5. 00
6. 00	69. 00				68, 936			ol o	o	6. 00
7. 00	91. 00				1, 078, 705			ol o	o	7. 00
8. 00	0.00					0	C	ol o	o	8. 00
9. 00	0. 00					0	C	ol o	o	9. 00
10. 00	0.00					0	C	ol o	o	10.00
200.00					1, 946, 313	1, 946, 313	C		O	
	Wkst. A Line #		Cost	Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
				I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
						Limit	Conti nui ng	Share of col.	Insurance	
							Educati on	12		
	1. 00			2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00	5. 00				C	1			1	1. 00
2. 00	13. 00				C	0			0	2. 00
3. 00	50. 00				C	0		1	0	3. 00
4. 00	54. 00				C	0	_	1	0	4. 00
5. 00	60. 00				C	0	_	1	0	5. 00
6. 00	69. 00				C	0	C	0	0	6. 00
7. 00	91. 00		G		C	0	C) 0	0	7. 00
8. 00	0. 00				C	0	C	1	0	8. 00
9. 00	0. 00				C	0	C	1	0	9. 00
10. 00	0. 00				C	0	_	1	0	
200.00				0 1 (8)		0		_	0	200. 00
	Wkst. A Line #		Cost	Center/Physi ci an	Provi der	Adjusted RCE	RCE	Adjustment		
				Identifier	Component	Limit	Di sal I owance			
					Share of col.					
	1. 00			2. 00	15. 00	16. 00	17. 00	18. 00	-	
1.00	5. 00	ΠP	Λ	2.00	13.00					1. 00
2. 00	13. 00									2. 00
3.00	50.00					Ö				3. 00
4. 00	54.00					Ö		1	1	4. 00
5. 00	60.00					0		1,		5. 00
6.00	69. 00					0	_	1		6. 00
7. 00	91. 00					Ö		1		7. 00
8.00	0.00		J			0	_			8. 00
9. 00	0.00					0		1		9. 00
10. 00	0.00					0	_	1		10. 00
200.00	5.00					Ö				200. 00
200.00	ı	ı			1	1		1, 710, 515	1	200.00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0183

					Τ̈́	0 12/31/2018	Date/Time Pre	
				CAPI TAL REI	ATED COSTS		5/26/2019 12:	54 pili
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		cost center bescription	for Cost	DLUG & FIXI	WVBLE EQUIP	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	4 402 040	4 402 040				1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT	4, 692, 948 195, 221	4, 692, 948	195, 221			1. 00 2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3, 019, 689		139			4. 00
5.00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	7, 634, 133	960, 123 0		414, 187	9, 048, 382	5. 00
6. 00 7. 00		OPERATION OF PLANT	280, 341 1, 020, 427	135, 604	· -	83, 332	280, 341 1, 245, 004	6. 00 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	78, 532	24, 728	1, 029	O	104, 289	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	409, 759 465, 428			77, 059 79, 175	486, 818 759, 181	9. 00 10. 00
11. 00	1	CAFETERIA	-112, 444		0, 370	79, 173	-112, 444	11. 00
13. 00		NURSING ADMINISTRATION	1, 414, 262	53, 370		292, 765	1, 762, 617	13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	121, 505 32, 956		0	126, 559 34, 327	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	201, 603	10, 007		39, 281	251, 307	16. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	1 2/0 2/0	224 7/2	12.02/	252 052	2 072 001	20.00
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	1, 369, 360 811, 025			353, 952 211, 925	2, 072, 001 1, 250, 081	30. 00 31. 00
32. 00	03200	CORONARY CARE UNIT	0	0		0	0	32. 00
33. 00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0		0	0	34. 00 40. 00
41. 00	04100	SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45. 00		NURSING FACILITY	0	0		0	0	44. 00 45. 00
46. 00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	1, 564, 004	501, 855	20, 877	264, 231	2, 350, 967	50. 00
51. 00	1	RECOVERY ROOM	0	0		204, 231	2, 330, 707	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	1, 204, 107	0 360, 024	14, 977	0 212, 167	0 1, 791, 275	53. 00 54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00		RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	57. 00 58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	0	0	O	0	59. 00
60. 00 60. 01		LABORATORY BLOOD LABORATORY	1, 114, 268	108, 119	4, 498	247, 118	1, 474, 003 0	60. 00 60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0	U			0	61. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	o	0	62. 00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0	0	0	0	
65. 00		RESPI RATORY THERAPY	361, 945	_		96, 634	486, 698	65. 00
66. 00	1	PHYSI CAL THERAPY	106, 678	0	0	29, 200	135, 878	66. 00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	233, 061	0	Ö	60, 138	293, 199	
70. 00 71. 00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	2, 088, 945 849, 157	0		46, 317 0	2, 135, 262 849, 157	71. 00 72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	809, 016	0	0	94, 807	903, 823	73. 00
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0	0	0	0	74. 00 75. 00
76. 98		WOUND CARE	357, 925	_	·	80, 312	651, 332	76. 98
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC		0	0	O	0	88. 00
89. 00	1	FEDERALLY QUALIFIED HEALTH CENTER	l o	0	1	o	0	89. 00
90.00		CLINIC	0	0	0	0	0	90.00
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	1, 284, 033	261, 246	10, 868	311, 634	1, 867, 781 0	91. 00 92. 00
, 2. 00	OTHER	REIMBURSABLE COST CENTERS					0	, 2. 50
94.00		HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 96. 00		AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED		0	0 0	0	0	95. 00 96. 00
97. 00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	o	0	97. 00
98. 00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0183	Peri od: Worksheet B

From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Cost Center Description Net Expenses MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 99. 00 09900 CMHC 0 0 0 0 99.00 99. 10 09910 CORF 0 0 99. 10 C Ω 99. 11 | 09911 | CORF 0 0 0 0 0 99. 11 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106. 00 0 0 0 0 0 107.00 10700 LIVER ACQUISITION 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 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.) 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 453, 423 3, 563, 285 148, 229 2, 994, 234 30, 247, 838 118. 00 NONREI MBURSABLE COST CENTERS 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 915, 116 38,068 0 953, 184 192. 00 193.00 19300 NONPALD WORKERS 0 193.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 0 194. 01 07951 PUBLIC RELATIONS 136, 873 1, 067 44 28, 930 166, 914 194. 01 194. 02 07952 MOB 8, 880 222, 360 194. 02 213, 480 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 31, 590, 296 4, 692, 948 195, 221 3, 023, 164 31, 590, 296 202. 00

Provider CCN: 15-0183

					0 12/31/2018	Date/lime Pre 5/26/2019 12:	
	Cost Center Description	ADMI NI STRATI VE			LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	9, 048, 382					5. 00
6.00	00600 MAINTENANCE & REPAIRS	111, 971	392, 312	1			6. 00
7.00	00700 OPERATION OF PLANT	497, 267	14, 264				7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	41, 654 194, 440	2, 601	12, 086	160, 630	681, 258	8. 00 9. 00
10. 00	01000 DI ETARY	303, 224	21, 670	ή	0	39, 321	1
11. 00	01100 CAFETERI A	0	2., 5, 6	0	Ö	0	11. 00
13.00	01300 NURSING ADMINISTRATION	704, 007	5, 614	26, 085	0	10, 187	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	50, 549	12, 781	1	0	23, 192	14. 00
15. 00	01500 PHARMACY	13, 711	3, 467	1	0	6, 290	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	100, 375	1, 053	4, 891	0	1, 910	16. 00
30. 00	03000 ADULTS & PEDIATRICS	827, 578	35, 214	163, 617	121, 715	63, 897	30. 00
31. 00	03100 INTENSIVE CARE UNIT	499, 295	22, 938	1			31. 00
32.00	03200 CORONARY CARE UNIT	0	C	0	0	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0			0	0	34. 00 40. 00
41. 00	04100 SUBPROVIDER - IRF	l ő	C	ól ő	Ö	0	41.00
43.00	04300 NURSERY	O	C	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	C	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	C	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	C)[0	0	46. 00
50. 00	05000 OPERATING ROOM	939, 003	52, 791	245, 285	0	95, 791	50.00
51. 00	05100 RECOVERY ROOM	0	C	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	C	0	0	0	53. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	715, 453	37, 872	175, 964	0	68, 719 0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE				0	0	56.00
57. 00	05700 CT SCAN	0	C	o o	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	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 06001 BLOOD LABORATORY	588, 732	11, 373	52, 844	0	20, 637 0	60. 00 60. 01
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	c	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C) o	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	C	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	194, 392	2, 840	13, 195	0	5, 153	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	54, 271			0	0	66. 00 67. 00
	06800 SPEECH PATHOLOGY	Ö	Č	o o	0	Ö	
	06900 ELECTROCARDI OLOGY	117, 107	C	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	852, 845	C	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	339, 162 360, 996			0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0	Č	o o	0	Ö	74.00
	07500 ASC (NON-DISTINCT PART)	0	C	0	0	0	75. 00
76. 98	07698 WOUND CARE	260, 149	21, 521	99, 992	0	39, 050	76. 98
77. 00	07700 ALLOGENEI C STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	C) 0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	Č	o o	0	Ö	89. 00
90.00	09000 CLI NI C	0	C	0	0	0	90. 00
91. 00	09100 EMERGENCY	746, 010	27, 481	127, 686	0	49, 865	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	(0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	O	C	ol o	o o	0	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	Ċ	o o	0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C	0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	C	0	0	0	98.00
99.00	09900 CMHC 09910 CORF	0	C	0	0	0	99. 00 99. 10
	09911 CORF		,) 0	0	0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	l ől	Č	o o	Ö		100.00
	10100 HOME HEALTH AGENCY	0	C) 0	0		101. 00

					5/26/2019 12:	54 pm
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6.00	7. 00	8. 00	9. 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 ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 512, 191	273, 480	1, 204, 406	160, 630	465, 634	118. 00
NONREI MBURSABLE COST CENTERS						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	380, 711	96, 264	447, 267	0	174, 672	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 PUBLIC RELATIONS	66, 667	112	522	0	204	194. 01
194. 02 07952 MOB	88, 813	22, 456	104, 340	0	40, 748	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)	9, 048, 382	392, 312	1, 756, 535	160, 630	681, 258	202. 00
			•	•		

Provider CCN: 15-0183

				To	12/31/2018	Date/Time Pre 5/26/2019 12:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	J
	GENERAL SERVICE COST CENTERS	10.00	11. 00	13. 00	14. 00	15. 00	
1, 00 2, 00 4, 00 5, 00 6, 00 7, 00 8, 00 10, 00 11, 00 13, 00 14, 00 16, 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 224, 084 614, 821 0 0 0	502, 377 24, 916 0 0 14, 015	2, 533, 426 0 0	272, 468 0 0	73, 902 0	
30. 00 31. 00 32. 00 33. 00 40. 00 41. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY	555, 430 52, 139 0 0 0 0 0 0 0 0	91, 789 48, 577 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 60. 01 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06900 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07698 WOUND CARE 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50, 826 0 0 0 52, 253 0 0 0 0 0 55, 627 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00 68. 00 69. 00 70. 00 71. 00 73. 00 74. 00 75. 00 76. 98 77. 00
88. 00 89. 00 90. 00 91. 00 92. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0 0 0 1,694	0 0 0 88, 935	0 0 0 844, 475	0 0 0 0	0 0 0 0	88. 00 89. 00 90. 00 91. 00 92. 00
99. 11	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC 09910 CORF	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	

Provider CCN: 15-0183

			To	12/31/2018	Date/Time Prepare 5/26/2019 12:54 p	:d:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	111
oust contain bescription	DI EI/IIII		ADMI NI STRATI ON	SERVICES &	110000001	
				SUPPLY		
	10.00	11. 00	13.00	14. 00	15. 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.	
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 ACQUISITION	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	0 115.	00
116. 00 11600 HOSPI CE	0	0	0	0	0 116.	00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 224, 084	498, 397	2, 533, 426	272, 468	73, 902 118.	00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.	
191. 00 19100 RESEARCH	0	0	0	0	0 191.	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.	
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193.	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.	
194. 01 07951 PUBLIC RELATIONS	0	3, 980	0	0	0 194.	
194. 02 07952 MOB	0	0	0	0	0 194.	
200.00 Cross Foot Adjustments					200.	
201.00 Negative Cost Centers	0	0	0	0	0 201.	
202.00 TOTAL (sum lines 118 through 201)	1, 224, 084	502, 377	2, 533, 426	272, 468	73, 902 202.	00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0183 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/26/2019 12:54 pm Cost Center Description MEDI CAL Total Subtotal Intern & RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 373, 551 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 4, 792, 866 30.00 03000 ADULTS & PEDIATRICS 4, 792, 866 17 149 30.00 0 31.00 03100 INTENSIVE CARE UNIT 7,645 2, 067, 791 2, 067, 791 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34 00 Ω 34 00 0 0 40.00 04000 SUBPROVIDER - IPF C 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44 00 44.00 Ω 0 45.00 04500 NURSING FACILITY 0 45.00 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 37, 136 4, 616, 274 0 4, 616, 274 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 74.445 2, 915, 981 2, 915, 981 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 Ω 0 0 56.00 0 05700 CT SCAN 57.00 0 57.00 C 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 Ω 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 57, 514 2, 260, 730 2, 260, 730 60.00 60.00 06001 BLOOD LABORATORY 0 60.01 C 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 0 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 14.892 736, 030 736, 030 65.00 06600 PHYSI CAL THERAPY 196, 476 66.00 1.742 196, 476 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 7,700 427, 998 427, 998 69.00 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 44,667 3, 237, 443 0 3, 237, 443 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 21, 212 1, 296, 536 0 1, 296, 536 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 13, 987 1, 371, 524 1, 371, 524 73.00 74 00 07400 RENAL DIALYSIS 0 74 00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 07698 WOUND CARE 12, 143 1, 084, 187 1, 084, 187 76. 98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 89.00 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 3, 817, 246 0 3, 817, 246 63.319 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 0 95.00 09500 AMBULANCE SERVICES C 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98 00 0 98.00 0 99.00 09900 CMHC 0 99.00

99.10

99. 10 09910 CORF

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0183 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm Cost Center Description MEDI CAL Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 24.00 26.00 25.00 99. 11 | 09911 | CORF О 99. 11 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 0 0 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 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 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115. 00 0 Ω 0 0 116. 00 11600 HOSPI CE 0 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 373, 551 28, 821, 082 0 28, 821, 082 118. 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 0 192. 00 0 2, 052, 098 2, 052, 098 193. 00 19300 NONPALD WORKERS 0 193. 00 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 194. 01 07951 PUBLIC RELATIONS 0 238, 399 238, 399 194. 01 194. 02 07952 MOB 0 0 194. 02 478, 717 478, 717 0 0 0

373, 551

31, 590, 296

200.00

201. 00

202. 00

0

31, 590, 296

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time Prepared: | 5/26/2019 | 12:54 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0183

COST Center Description						10	12/31/2018	5/26/2019 12:	
PRINCIPLE PRIN					CAPI TAL REI	LATED COSTS			
Debugger Debugger			Cost Contar Decement on	Dimontly	DIDC 0 FLVT	M/DLE FOLLD	Cubtatal	EMDL OVEE	
Capital Selection Capital Selection Capital Selection Capital Selection Capital Capita			Cost Center Description	, ,	BLDG & FIXI	MARTE EGOLD	Subtotai		
Relatical Classis									
DEFENDED SERVICE COST CENTERS 1.00									
0.000 GOTOG CAP REL COSTS-BLIG & FIXT				0	1.00	2.00	2A	4. 00	
2.00	4 00			1		ı			4 00
4.00 GOODG JERROYTE INFELTIS DEPARTMENT 0 3.336 3.97 3.475 4.00 6									
5.00 OSCOLD AMENI INSTRUTIVE A GRIFFINEM 0 940, 173 39, 939 1,000, 662 474 8.00 0 0 0 0 0 0 0 0 0				0	3 336	130	3 475	3 475	
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11.10 (0 1100) CAFETERIA		1	l control of the cont	0	0	0	0		
13.00 01300 NIRSH NG ADMINI STRATION 0 53,370 2,220 55,590 337 13.00		1	ł	0	206, 008	8, 5/0	214, 5/8		
14.00 01400 CENTRAL SERVICES & SUPPLY 0 121,505 5,054 126,559 0 14.00 15.00 1500 01400 PARRACY 0 10.007 410 10.423 45 16.00 10.007 1		1	1		53 370	2 220	55 590	-	
15.00 01500 PIAMANACY 0 32,956 1,371 34,327 015,00				l o					
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45. 00 04500 OHREN ROR FERN CARE				0	0	0	0	-	
46. 00 04600 OTHER LONG TERM CARE				0	0	0	0	-	
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55.00 05500 RADIO LOGY-THERAPEUTIC					360 024	14 977	375 001	-	
56.00 05600 RADIO I SOTOPE 0 0 0 0 0 0 0 0 0 57.00		1	l control of the cont		0	0	0		
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SP 00 05900 CARDI AC CATHETER IZATI ON 0 0 0 0 0 59 00		1		0	0	0	0	-	
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60.01		1	l control of the cont	0	-		112 617	-	
61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRCM ONLY 0 0 0 0 0 0 0 0 0 0 0 62.00					100, 117	4, 470	112, 017		
63.00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76.98 07698 WOUND CARE 0 0 0 0 0 77.00 07000 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 79.00 07000 CLITIC STEWICE COST CENTERS 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 79.00 09000 CLINIC 0 0 0 0 79.00 09000 CLINIC 0 0 0 0 79.00 09000 CLINIC 0 0 0 79.00 09000 DURBLE MEDI CAL EQUI PRENTED 0 0 0 79.00 09000 DURBLE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09700 DURBALE MEDI CAL EQUI PRENTED 0 0 0 79.00 09					· ·		Ö	o .	
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66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 34 66. 00 67. 00 06700 0CCUPATI IONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 76. 98 07698 WOUND CARE 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 79. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 88. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 90. 00 09000 CLI NI C 0 0 0 0 0 91. 00 09000 CLI NI C 0 0 0 0 92. 00 09000 CLI NI C 0 0 0 0 0 94. 00 09400 OBERGENCY 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 96. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0				0	-	-	-1	-	
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94. 00	92.00						o		92. 00
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 95. 00 96. 00 97. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 98. 00 0 98. 00 0 98. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	04.00						اء		04.00
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99. UU U99UU CMHC 0 0 0 99. 00				0			0		
	99. 00	09900	I CMHC	0	0	0	이	0	99. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II

			To	12/31/2018	Date/Time Prepare 5/26/2019 12:54 p	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal Rel ated Costs				DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
99. 10 09910 CORF	0	0	2.00	0	0 99.	10
99. 11 09911 CORF	0	0	0	0	0 99.	
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	l ol	0	Ö	o	0 100.	
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.	
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107.	00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108.	
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109.	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.	
111.00 11100 I SLET ACQUISITION	0	0	0	0	0 111.	
113.00 11300 INTEREST EXPENSE					113.	
114.00 11400 UTILIZATION REVIEW-SNF					114.	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115.	
116. 00 11600 H0SPI CE	0	0	0	0	0 116.	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 563, 285	148, 229	3, 711, 514	3, 442 118.	00
NONREI MBURSABLE COST CENTERS		٥		ما	0 100	00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0	0	U O	0 190. 0 191.	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	915, 116	38, 068	953, 184	0 191.	
193. 00 19300 NONPALD WORKERS		913, 110	30,000	900, 104	0 192.	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS		0	0	0	0 193.	
194. 01 07951 PUBLI C RELATIONS		1, 067	44	1, 111	33 194.	
194. 02 07952 MOB		213, 480		222, 360	0 194.	
200.00 Cross Foot Adjustments	١	213, 400	3, 000	222, 300 N	200.	
201.00 Negative Cost Centers		0	0	0	0 201.	
202.00 TOTAL (sum lines 118 through 201)	0	4, 692, 948	195, 221	4, 888, 169	3, 475 202.	

Provider CCN: 15-0183

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time Prepared: | 5/26/2019 | 12:54 pm

Substitution							5/26/2019 12:	
SHEME SENSITE DIST CONTINUES F. 177		Cost Center Description			OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
FRENCH SERVICE COST CENTERS 1.00 COOTING CARRIER COST CENTERS 1.00 COOTING CARRIER COST CENTERS 1.00 COOTING CARRIER COST CENTERS 1.00 COOTING CARRIER COST CARRIERS 1.00 COOTING CARRIER							9 00	
2.00 DOORD CAP ST. LOSTS WHILE FORLEY 1,000,556 1,304 31,709 1,500 5,00		GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0. 00	7.00	
0.000 DOUGNE DEPARTUREN 1,000,536 5.00 COSCO ANNIN TRADRET & REPAIRS 1,000,536 6.00 COSCO ANNIN TRADRET & REPAIRS 12,386 19,387 146,777 6.00 COSCO ANNIN TRADRET & REPAIRS 12,386 19,387 146,777 6.00 COSCO ANNIN TRADRET & REPAIRS 1,000,536 1,000								
0.00 0.000 AUM INSTRUCT & CEMERAL 1,000,526								
0.000 0.0000 MAINTERNACE & REPAIRS 12.381 12.381 1.2.8			1 000 524					
0.000 00000 (AURDY & LINES SERVICE \$ 1,000 000000 (AURDY & LINES SERVICE \$ 1,000 000				12 381				
B. DO			1					
10.00 01000 DETARY			1			31, 799		
11-00 0 1000 CAFETERIA			1	0	0	0	21, 589	9. 00
13.00 01300 MIRES NA ADMINI STRATION			1			0		
14.00 01-400 PARISHACY 1.516 100 1.504 0 109 15.00			_	-	_	0		
15.00 1500 PARSMACY			1			0		
16. 00						0		
30.00			1		·	0		
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45. 00 04500 OHER LONG TERM CABE		1	0	0	0	0	0	
A6. 00 OLGOO OTHER LONG TERN CARE			0	0	0	0		
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11.00			12, 949	0	0	0	0	
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From 01/01/2018 Part II 12/31/2018 Date/Time Prepared:

5/26/2019 12:54 pm ADMINISTRATIVE MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS PLANT LINEN SERVICE 9. 00 5.00 6.00 8.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 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 ACQUISITION 0 0 0 0 0 111.00 113. 00 11300 | NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 0 0 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 941, 246 8, 629 134, 925 31, 799 14, 756 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 191. 00 191. 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 42, 097 3,039 50, 105 0 5, 536 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 00 0 0 194. 01 07951 PUBLIC RELATIONS 0 6 194. 01 7.372 58 194. 02 07952 MOB 9,821 709 11,689 1, 291 194. 02 200.00 200.00 Cross Foot Adjustments Negative Cost Centers 0 201. 00 201.00 31, 799 202.00 TOTAL (sum lines 118 through 201) 1,000,536 12, 381 196, 777 21, 589 202. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0183

				To	12/31/2018	Date/Time Pre 5/26/2019 12:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	J 1 PIII
	CENEDAL CEDIUSE COCT CENTEDO	10.00	11. 00	13. 00	14. 00	15. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BUDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	261, 408 131, 297 0 0	107, 284 5, 321 0 0 2, 993	142, 516 0 0	139, 939 0 0	37, 955 0	1
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	110 (14	10 (02	47.50/	٥	-	1 20 00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	118, 614 11, 135 0 0 0 0 0 0 0 0	19, 602 10, 374 0 0 0 0 0 0 0	47, 506 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
F0 00	ANCILLARY SERVICE COST CENTERS		40.054	17.505			F0 00
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06600 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07698 WOUND CARE 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 854 0 0 0 11, 159 0 0 0 11, 159 0 0 0 11, 879 0 0 4, 028 979 0 2, 134 0 4, 101 0 4, 018	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 98 77. 00
90. 00 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 362	0 0 0 18, 992	0	0 0 0 0	0 0 0 0	88. 00 89. 00 90. 00 91. 00 92. 00
96. 00 97. 00 98. 00 99. 00 99. 10 99. 11	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DI ALYSI S O9500 AMBULANCE SERVI CES O9600 DURABLE MEDI CAL EQUI P-RENTED O9700 DURABLE MEDI CAL EQUI P-SOLD O9850 OTHER REI MBURSABLE COST CENTERS O9900 CMHC O9910 CORF O9911 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	94. 00 95. 00 96. 00 97. 00 98. 00 99. 00 99. 10 99. 11 100. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Provider CCN: 15-0183

			To	12/31/2018	Date/Time Pre 5/26/2019 12:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	J PIII
			ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 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		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 SLET ACQUISITION	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		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	261, 408	106, 434	142, 516	139, 939	37, 955	118.00
NONREI MBURSABLE COST CENTERS		ما		ما		100 00
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 CI ANS' PRI VATE OFFI CES	0	0	0	U		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	U		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	050	0	U O		194. 00 194. 01
194. 01 07951 PUBLIC RELATIONS 194. 02 07952 MOB	0	850	0	0		194. 01
	U	U	U	٩		200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		24, 013				200.00
202.00 TOTAL (sum lines 118 through 201)	261, 408	131, 297		139, 939		
202.00 TOTAL (Suil TITIES TTO LITTOUGH 201)	201, 400	131, 297	142, 310	139, 939	37, 900	1202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0183 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/26/2019 12:54 pm Cost Center Description MEDI CAL Total Subtotal Intern & RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 25, 202 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 673.046 1 158 673 046 30.00 0 31.00 03100 INTENSIVE CARE UNIT 516 326, 297 326, 297 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34 00 Ω 34 00 0 0 40.00 04000 SUBPROVIDER - IPF 0 0 40.00 04100 SUBPROVI DER - I RF 0 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 0 43.00 0 04400 SKILLED NURSING FACILITY 44 00 44.00 Ω 0 45.00 04500 NURSING FACILITY 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 2.507 719, 919 0 719, 919 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 5.008 493, 610 493, 610 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 05600 RADI OI SOTOPE 0 56.00 0 Ω 0 56.00 0 05700 CT SCAN 57.00 0 57.00 C 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 C 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 06000 LABORATORY 3,883 200, 695 0 200, 695 60.00 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 0 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 1.005 56, 489 56, 489 65.00 06600 PHYSI CAL THERAPY 0 66.00 118 7.132 7.132 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 520 15, 672 15, 672 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 3,016 196, 727 0 196, 727 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 432 83, 621 0 83, 621 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 944 82, 943 0 82, 943 73.00 74 00 07400 RENAL DIALYSIS 0 74 00 0 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 75.00 07698 WOUND CARE 820 255, 891 0 255, 891 76. 98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 89.00 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 0 442, 849 4.275 442.849 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS Ô 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 95.00 09500 AMBULANCE SERVICES C 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98 00 0 98.00 0 99.00 09900 CMHC 0 0 99.00

99. 10

99. 10 09910 CORF

near til Fillanci ar Systems	WONKUE HUSP	ITAL		III LI E	u 01 F01111 CM3-2332-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0183	Peri od:	Worksheet B
				From 01/01/2018	
				To 12/31/2018	
	HED! ON			-	5/26/2019 12:54 pm
Cost Center Description	MEDI CAL	Subtotal	Intern &	Total	
	RECORDS &		Residents Cos	st	
	LI BRARY		& Post		
			Stepdown		
			Adjustments		
	16. 00	24. 00	25. 00	26. 00	
99. 11 09911 CORF	0	0		0	99. 11
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0		0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	106. 00
107.00 10700 LIVER ACQUISITION	0	0		0	107. 00
108.00 10800 LUNG ACQUISITION	0	0		0	108. 00
109.00 10900 PANCREAS ACQUISITION	O	0		0 0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0		0	110.00
111.00 11100 I SLET ACQUI SI TI ON	O	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.)	o	0		0 0	115.00
116. 00 11600 HOSPI CE	o	0		0 0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	25, 202	3, 554, 891		0 3, 554, 891	118. 00
NONREI MBURSABLE COST CENTERS	20,202	070017071		0 0,00.,07.	1.5.55
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190. 00
191. 00 19100 RESEARCH	Ö	0		0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	Ö	1, 053, 961		0 1, 053, 961	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0 1,000,701	193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	194. 00
194. 01 07951 PUBLIC RELATIONS	0	9, 434		0 9, 434	
194. 02 07952 MOB	0	245, 870		0 245, 870	194. 02
200.00 Cross Foot Adjustments	٩	243,070		0 243,670	200. 00
201.00 Negative Cost Centers		24, 013		0 24, 013	
202.00 TOTAL (sum lines 118 through 201)	25, 202	4, 888, 169	l .	0 4, 888, 169	
202.00 TOTAL (Suill TITIES TTO LITTOUGH 201)	23, 202	4, 000, 109	I	U 4, 000, 109	202.00

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provi der CCN: 15-0183

COST Center Description						o 12/31/2018		
CENERAL SERVICE COST CENTERS			CAPI TAL REI	ATED COSTS			3/20/2014 12.	J4 pili
CENERAL SERVICE COST CENTERS		Cost Center Description	RIDG & FLYT	MVRLE FOLLE	FMPLOVEE	Reconciliation	ADMI NI STRATI VE	
CENTRAL SERVICE COST CENTERS		Sost contor bescription			BENEFITS	Receiver Fraction	& GENERAL	
SEASON CONTROL CONTR							(ACCUM. COST)	
ENERAL SERVICE COST CENTERS 1.00 DOTORO DAP RILL COSTS IND 0.5 F1Y TO 5. 51Y TO 5.								
0.00 0.0100 CAP REL COSTS-BLOG & FIXT 105, 519 1.09, 37, 0.04 2.00 0.000		CENEDAL SEDVICE COST CENTEDS	1. 00	2.00	4. 00	5A	5. 00	
4.00 004000 MINI-DIVER BENEFITS DEPARTMENT 75 75 10,979,004. 4.00 00500 MINI RISTARI IVE & GENERAL 21,588 3,049 30.49 30.49 30.49 30.49 22,654.398 5.00 6.00 00500 MINITERANCE & REPAIRS 0 0 0 778,778 0 10,200 00700 MINITERANCE & REPAIRS 0 0 778,778 0 0.788 30.49 30	1.00		105, 519					1. 00
0.0000 0.0000 0.0001 0				1				
0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000			1				22 654 358	
BODD GORDO LANDRIFY & LINEN SERVICE 556 556 0 0 104, 289 8 00 900 00090 DUSEXEEPIN 0 466, 818 9.00 10.00 DIETARY 4, 632 4, 632 286, 434 0 759, 181 10.00 11.00 01.00			0	0	_	_		
9.00 0.9900 HOUSEKEEN ING			1					
10.00 01000 DIFTARY			556	l		_		
13.00 01300 NURSIN RADMIN STRATION 1,200 1,200 1,059,148 0 1,762,617 13.00 15.00 01500 PHARMACY 27.732 2,722 0 01500 PHARMACY 25.732 14.00 0 34.337 15.00 15.00 01500 PHARMACY 27.732 22.5 22.5 14.2 10 0 25.1397 16.00 15.00 01500 PHARMACY 27.732 27.752 22.5 27.752			4, 632	·				
14.00 01400 CENTRAL SERVICES & SUPPLY			0	0	1			
15.00 01500 PHARMACY 741			1	l				
INPATI ENT ROUTI NE SERVICE COST CENTERS 7, 527 7, 527 1, 280, 503 0 2, 072, 001 30. 00 31. 00 33.00 03100 DULTS & FEDILATIC S 7, 527 7, 527 1, 280, 503 0 2, 072, 001 31. 00 32. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 34.	15. 00	01500 PHARMACY	741	741	C	-		
30. 00	16. 00		225	225	142, 109	0	251, 307	16. 00
32.00 03200 CORONARY CARE UNIT	30. 00		7, 527	7, 527	1, 280, 503	0	2, 072, 001	30. 00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 3. 00 40. 00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 3. 40. 00 41. 00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			4, 903		766, 690	0	1, 250, 081	
34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0			0	0	·	_		
41.00 04100 SUBROVI DER - 1 RF			0	0	·	_		
43.00 04300 NURSERY			0	0	C	0		
44. 00 04400 SKILLED NURSING FACILITY			0	0		0		
46.00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0			0	0		0		
ANCILLARY SERVICE COST CENTERS			0	0				
50.00 05000 05000 05000 05000 05000 051.00 050.00	46. 00		0	0) 0	0	46. 00
52.00 05200 05200 0521 VERY ROOM & LABOR ROOM 0 0 0 0 0 52.00	50. 00		11, 284	11, 284	955, 917	0	2, 350, 967	50. 00
53.00 05.300 05			0	0		-		
54.00 05400 RADI 0LGY-DI AGNOSTI C S 0.00 C 0 0 0 0 0 0 0 0			0	0		-		
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 56. 00			8, 095	8, 095	1	_	-	
57.00 05700 CT SCAN 0 0 0 0 0 0 57.00			0	0	1	1		
58.00 05800 MAGNETI C RESONANCE I MAGING (MRI)			0	0				
60. 00 06000 LABORATORY 2, 431 2, 431 894, 007 0 1, 474, 003 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0	58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	ő	1	1		58. 00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60. 01 61. 00 06100 PBP CLI INI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 66. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 67. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 68. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76. 98 07698 WOUND CARE 4,600 4,600 290,548 0 651,332 77. 00 07900 ALLOGENEIC SENLL ACQUI SI TI ON 0 0 0 0 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 91. 00 09100 ELERGENCY 5,874 5,874 1,127,411 0 1,867,781 91.00 91. 00 09100 ELERGENCY 5,874 5,874 5,874 1,127,411 0 1,867,781 91.00 91. 00 09100 ELERGENCY 5,874 5,874 5,874 1,127,411 0 1,867,781 91.00 91. 00 09100 ELERGENCY 5,874 5,874 5,874 1,127,411 0 1,867,781 91.00 91. 00 09100 ELERGENCY 5,874 5,874 5,874 5,874 1,127,411 0 1,867,781 91.00 91. 00 09100 ELERGENCY 5,874 5,874 5,874 5,874 1,127,411 0 1,867,781 91.00 91. 00 09100 ELERGENCY 5,874 5,874 5,874 5,874 1,127,411 0 1,867,781 91.00 91. 00 09100 ELERGENCY 5,874 5,874 5,874 5,874 5,874 5,874 5,874 5,874 5			0	0	1	_		
61. 00			2, 431	2, 431	1			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63. 00 64. 00 64.00 1NTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 65. 00 66500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 64. 00 65. 00 66500 RESPI RATORY THERAPY 0 0 0 0 105, 637 0 135, 878 66. 00 66. 00 66600 PHYSI CAL THERAPY 0 0 0 0 105, 637 0 135, 878 66. 00 67. 00 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 68. 00 67. 00 68. 00 68800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 68. 00 699. 0	61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61. 00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 607 607 349, 598 0 486, 698 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 105, 637 0 135, 878 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70. 00 07000 ELECTROSHOEPHALOGRAPHY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 167, 562 0 2, 135, 262 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 76. 98 07698 WOUND CARE 4,600 4,600 290,548 0 651, 332 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0 90. 00 09900 CLI NI C 0 0 0 0 0 0 91. 00 09100 EMERGENCY 5,874 5,874 1,127,411 0 1,867,781 91. 00		1	0	0		0		
66. 00 06600 PHYSI CAL THERAPY 0 0 105, 637 0 135, 878 66. 00 67. 00 06700 0000 0000 0000 0000 0000 0000 0000 0000 0000 000000			0	0		0		
67. 00			607	l				
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 217, 565 0 293, 199 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 167, 562 0 2, 135, 262 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 849, 157 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 342, 987 0 903, 823 73. 00 74. 00 07400 RENAL DI IALYSIS 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76. 98 07698 WOUND CARE 4, 600 4, 600 290, 548 0 651, 332 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 91. 00 09100 EMERGENCY 5, 874 5, 874 1, 127, 411 0 1, 867, 781 91. 00			0	0				
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 167, 562 0 2, 135, 262 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 342, 987 0 903, 823 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 76. 98 07698 WOUND CARE 4,600 4,600 290,548 0 651, 332 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 89. 00 09900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 99. 00 09900 CLINI C 0 0 0 0 91. 00 09100 EMERGENCY 5,874 5,874 1,127,411 0 1,867,781 91. 00			0	ő				
71. 00			0	0	217, 565	0		
72. 00			0	0	167 562	0		
74. 00			Ö	ő	(07,002	0		
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 98 07698 WOUND CARE 4,600 4,600 290,548 0 651,332 76. 98 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0			0	0				
76. 98 07698 WOUND CARE 4,600 4,600 290,548 0 651,332 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0			0	0		-		
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 0 90.00 91.00 09100 EMERGENCY 5,874 5,874 1,127,411 0 1,867,781 91.00	76. 98	07698 WOUND CARE	4, 600	4, 600	1	_		
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 0 89. 00 90. 00 0 0 0 0 0 0 0 0	77. 00		0	0		0	0	77. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 90. 00 91. 00 91. 00 5, 874 5, 874 1, 127, 411 0 1, 867, 781 91. 00	88. 00		0	0) 0	0	88. 00
91. 00 09100 EMERGENCY 5, 874 5, 874 1, 127, 411 0 1, 867, 781 91. 00	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ō				89. 00
			0	0	1 127 411	_		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00			5,8/4	5,874	[1, 1∠7, 411 		1,807,781	
OTHER REIMBURSABLE COST CENTERS		OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S O O O O 94. 00 95. 00 09500 AMBULANCE SERVI CES O O O O 95. 00 O O O O O O O O O			0	0				
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 95. 00 96. 00 96. 00 0 96. 00				0		0		
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00	97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		-		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98. 00	98. 00	U985U UIHER REIMBURSABLE COST CENTERS	0	0	1 0) O	0	98. 00

CAPITAL RELATED COSTS BIDG & FIXT (SQUARE FEET) WINDLE COULT CAPITAL RELATED COSTS BIDG & FIXT (SQUARE FEET) BINEFITS BENEFITS BENEFITS BENEFITS BENEFITS SALARIES) SALARIES SALARIES) SALARIES) SALARIES) SALARIES) SALARIES SALARIES) SALARIES SALARIES) SALARIES					11	0 12/31/2018	5/26/2019 12:5	
Cost Center Description			CAPLTAL REL	ATED COSTS			372072017 12.3	ут рііі
SOUARE FEET SOUARE FEET SOUARE FEET BENEFITS CACCUM. COST)								
SOUARE FEET SOUARE FEET SOUARE FEET BENEFITS CACCUM. COST)		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
DEPARTMENT CROSS SALARIES) SALARIES SALARIE		p	(SQUARE FEET)					
1,00			,	,	DEPARTMENT			
99.00 09900 CMHC 0							(
99. 00 09970 CORF 0 0 0 0 0 0 0 0 0								
99.10 09910 CORF 0			1.00	2. 00		5A	5. 00	
99.11 COPF C	99.00 09900	CMHC	0	0	0	0	0	99. 00
100. 00 10000 LAR SERVI CES_NOT APPRVD PRGM 0 0 0 0 0 100. 00	99. 10 09910	CORF	0	0	0	0	0	99. 10
101.00 101.00 100.00 HEALTH AGENCY	99. 11 09911	CORF	0	0	0	0	o	99. 11
SPECIAL PURPOSE COST CENTERS	100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 -	100. 00
SPECIAL PURPOSE COST CENTERS	101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 -	101. 00
105.00 10500 KIDNEY ACQUISITION								
107.00 10700 LUVER ACQUISITION			0	0	0	0	0 1	105. 00
108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 10	106. 00 10600	HEART ACQUISITION	0	0	0	0	0 -	106. 00
108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 108. 00	107. 00 10700	LIVER ACQUISITION	0	0	0	0	01	107. 00
110.00 11000 NTESTI NAL ACQUISITION 0 0 0 0 0 110.00	108.00 10800	LUNG ACQUISITION	0	0	0	0	ol-	108. 00
110.00 11000 NTESTI NAL ACQUISITION 0 0 0 0 0 110.00	109. 00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109. 00
111. 00 11100 I SLET ACQUISITION 0 0 0 0 0 111. 00 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 0 0 115. 00 116. 00 116. 00 11600 HOSPICE 0 0 0 0 0 0 0 0 0			0	0	0	0		
113.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 115.00			0	0	0	0		
114.00					_			
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 0 0 115. 00 116. 00 11600 HOSPI CE								
116. 00 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) 80, 119 80, 119 10, 832, 344 -8, 935, 938 21, 311, 900 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 1	1 1		0	0	0	0	l	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 80, 119 80, 119 10, 832, 344 -8, 935, 938 21, 311, 900 118.00 NONNEE IMBURSABLE COST CENTERS		• • • • • • • • • • • • • • • • • • • •	0	0	o o	0	· ·	
NONREI MBURSABLE COST CENTERS 190.00 190000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191.00 191.00 19100 RESEARCH 0 0 0 0 0 0 191.00 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 20,576 20,576 0 0 953,184 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 194			80 119	80 119	10 832 344	-8 935 938		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 1910 RESEARCH 0 0 0 0 0 0 0 0 1910 RESEARCH 0 0 0 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 0 1910 RESEARCH 0 0 0 0 0 1910 RESEARCH 0 0 0 0 0 0 0 0 0 1910 RESEARCH 0 0 0 0 0 0 0 0 0 0 1910 RESEARCH 0 0 0 1910 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 1910 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 0 0 1910 RESEARCH 0 0 0 1910 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			557117	55, 117	10/002/011	0, 700, 700	21/011/700	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 193. 00 19300 NONPAI D WORKERS 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 194. 00 07951 PUBLIC RELATIONS 194. 02 07952 MOB 200. 00 Cost Foot Adjustments 201. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 207. 00 NAHE unit cost mult			0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.01 07951 PUBLIC RELATIONS 194.02 07952 WMOB 200.00 Cross Foot Adjustments 192.00 Nogative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D,			0	0		_		
193.00 19300 NONPAID WORKERS 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 194.00 194.01 07951 PUBLIC RELATIONS 194.02 07952 MOB 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAH			20, 576	20, 576	0	0	953, 184	192.00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 00 194. 01 194. 01 194. 01 194. 02 194. 01 194. 02 194. 03 194. 02 1			0	0	0	0		
194. 01 07951 PUBLIC RELATIONS 194. 02 07952 MOB 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part III) 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, Value 104, 800			0	0	0	0		
194.02 07952 MOB Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit			24	24	104, 660	0	l .	
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, Cross Foot Adjustments 200.00 201.00 201.00 201.00 202.00 201.00 201.00 202.00 201.00 202.00 203.00 1.850103 0.276416 0.399410 203.00 1.850103 0.276416 0.000318 0.000318 0.0004165 205.00 206.00 207.00					·	0		
201.00 202.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 207.00			.,	.,	_			
202.00 Cost to be allocated (per Wkst. B, Part I) 44.474910 1.850103 0.276416 0.399410 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 44.474910 1.850103 0.276416 0.399410 203.00 1,000,536 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000318								
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 Part I) 1. 850103 0. 276416 3, 475 0. 000318 0. 000318 0. 000318 0. 000318 0. 000318			4 692 948	195 221	3 023 164			
203.00 Unit cost multiplier (Wkst. B, Part I) 44.474910 1.850103 0.276416 0.399410 203.00 (Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.000318 0.00044165 (205.00 Unit cost multiplier (Wkst. B, Part II) 0.0044165 (205.00 Unit cost multiplier (Wkst. B, Part II) 0.0044165 (205.00 Unit cost multiplier (Wkst. B, Part II) 0.0044165 (205.00 Unit cost multiplier (Wkst. B, Part II) 0.000318 0.276416 (0.399410 203.00 Unit cost multiplier (Wkst. B, Part II) 0.000318 0.276416 (0.399410 203.00 Unit cost multiplier (Wkst. B, Part II) 0.000318 (0.206.00 Unit cost multiplier (Wkst. B, Part II) 0.00	202.00		1,0,2,,,0	.,0,22.	0,020,101		7,010,002	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 1,000,536 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000318 0.044165 205.00 10 10 10 10 10 10 10	203.00		44. 474910	1. 850103	0. 276416		0. 399410	203. 00
Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00					3, 475		1, 000, 536	204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00							, ,	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	205.00	Unit cost multiplier (Wkst. B. Part			0. 000318		0. 044165	205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00								
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206. 00	NAHE adjustment amount to be allocated					2	206. 00
Parts III and IV)	207. 00	NAHE unit cost multiplier (Wkst. D,					2	207. 00
		Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0183

				T	12/31/2018	Date/Time Pre 5/26/2019 12:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J P
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (PATIENT DAYS)	(SQUARE FEET)	(MEALS SERVED)	
		6. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	I					
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS	83, 856					6. 00
7.00	00700 OPERATION OF PLANT	3, 049	80, 807				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	556	556	1	00.051		8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	4, 632	4, 632	0	80, 251 4, 632	23, 125	9. 00 10. 00
11. 00	01100 CAFETERI A	0	4, 032	0	0	11, 615	1
13. 00	01300 NURSING ADMINISTRATION	1, 200	1, 200	0	1, 200	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 732	2, 732		2, 732	0	14. 00
15.00	01500 PHARMACY	741	741	•	741	0	15. 00
16. 00	O1600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	225	225	0	225	0	16. 00
30. 00	03000 ADULTS & PEDI ATRI CS	7, 527	7, 527	3, 209	7, 527	10, 493	30.00
31.00	03100 INTENSIVE CARE UNIT	4, 903	4, 903	1, 026	4, 903	985	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	· -	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0		0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	Ö	o o	0	Ö	41. 00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00	04500 NURSING FACILITY	0 0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS		0	<u> </u>	0	0	46. 00
50.00	05000 OPERATING ROOM	11, 284	11, 284	. 0	11, 284	0	50.00
51.00	05100 RECOVERY ROOM	0	O	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0 005	0	0 005	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	8, 095	8, 095 0	0	8, 095 0	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	0	Ö	o o	0	Ö	56. 00
57.00	05700 CT SCAN	0	O	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (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 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2, 431	2, 431		2, 431 0	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ĭ		J	, o	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	O	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	607	607 0		607 0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö	o o	Ö	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	O	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	o o	Ö	0	73. 00
74.00	07400 RENAL DIALYSIS	0	O	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 98	07698 WOUND CARE	4, 600	4, 600	0	4, 600	0	76. 98
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0		<u> </u>	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	O	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O	o o	0	0	89. 00
	09000 CLI NI C	0	0	0	0	0	90. 00
91.00	09100 EMERGENCY	5, 874	5, 874	0	5, 874	32	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	О	0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97.00	O9700 DURABLE MEDICAL EQUIP-SOLD O9850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	97. 00 98. 00
		0	n	, 0	0	0	99.00
	09910 CORF	0	Ö	ol o	0	0	99. 10
99. 11	09911 CORF	0	0	0	0	0	99. 11
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0 0	0	0	100. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B-1

From 01/01/2018
To 12/31/2019 Provider CCN: 15-0183

			T-	n 12/31/2018	Date/Time Pre 5/26/2019 12:	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, p
	REPAI RS	PLANT	LINEN SERVICE		(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(PATIENT DAYS)	` ,	,	
	6.00	7. 00	8. 00	9. 00	10.00	
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		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		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	58, 456	55, 407	4, 235	54, 851	23, 125	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	20, 576	20, 576	0	20, 576		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 PUBLIC RELATIONS	24	24		24		194. 01
194. 02 07952 MOB	4, 800	4, 800	0	4, 800		194. 02
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	392, 312	1, 756, 535	160, 630	681, 258	1, 224, 084	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	4. 678401	21. 737411	37. 929162	8. 489090	52. 933362	203. 00
204.00 Cost to be allocated (per Wkst. B,	12, 381	196, 777				1
Part II)	,	,		,		
205.00 Unit cost multiplier (Wkst. B, Part	0. 147646	2. 435148	7. 508619	0. 269018	11. 304130	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)						

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 01/01/2018 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL SERVICES & (FTE'S) ADMI NI STRATI ON (COSTED RECORDS & **SUPPLY** REQUIS.) LI BRARY (DIRECT NURS (COSTED (GROSS REQUIS.) HRS.) CHARGES) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11, 614 11.00 13.00 01300 NURSING ADMINISTRATION 576 6, 240 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 2, 659, 245 14.00 0 01500 PHARMACY 100 15 00 0 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 324 0 0 125, 476, 514 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 2 122 2.080 C 5, 760, 436 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 123 0 0 2, 568, 100 31.00 03200 CORONARY CARE UNIT 0 0 32.00 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34 00 Ω 0 34 00 0 40.00 04000 SUBPROVIDER - IPF C 0 0 40.00 0 04100 SUBPROVIDER - IRF 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 C 0 44 00 0 45.00 04500 NURSING FACILITY 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 1.175 2.080 0 0 12, 474, 255 51.00 05100 RECOVERY ROOM 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 52 00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 25, 004, 462 54.00 1, 208 C 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 0 56.00 05700 CT SCAN 0 0 57.00 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 0 06000 LABORATORY 0 19, 319, 440 60.00 1.286 60.00 06001 BLOOD LABORATORY 0 60.01 0 Λ 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 436 5, 002, 269 65.00 0 0 0 06600 PHYSI CAL THERAPY 0 585, 016 66.00 106 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 n 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 231 0 2, 586, 624 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 444 1, 810, 088 15, 003, 863 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 849, 157 0 7, 125, 381 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 435 100 4, 698, 393 73.00 C 74 00 07400 RENAL DIALYSIS 0 Ω 0 0 74 00 0 07500 ASC (NON-DISTINCT PART) 0 75.00 0 C 0 75.00 n 07698 WOUND CARE 0 0 0 0 4, 079, 041 76. 98 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 89.00 90.00 09000 CLI NI C 0 0 90.00 2,080 0 09100 EMERGENCY 2.056 0 21, 269, 234 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00

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0 99.00

0 99.10

96.00

97.00 0

98.00

99. 10 09910 CORF

09900 CMHC

09500 AMBULANCE SERVICES

09600 DURABLE MEDICAL EQUIP-RENTED

09850 OTHER REIMBURSABLE COST CENTERS

09700 DURABLE MEDICAL EQUIP-SOLD

95.00

96.00

97.00

98 00

99.00

In Lieu of Form CMS-2552-10
Period: Worksheet B-1
From 01/01/2018 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0183

				rom 01/01/2018	D 1 /T' D	
			To	12/31/2018	Date/Time Prep 5/26/2019 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	54 piii
cost center bescriptron	(FTE'S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
	(112 3)	ADMINI STRATION	SUPPLY	REQUIS.)	LI BRARY	
		(DIRECT NURS.	(COSTED	KLQUI 3.)	(GROSS	
		HRS.)	REQUIS.)		CHARGES)	
	11. 00	13. 00	14. 00	15. 00	16. 00	
99. 11 09911 CORF	11.00	13.00	14.00	13.00	0	99, 11
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	Ö	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	Ö	0	0		101.00
SPECIAL PURPOSE COST CENTERS		<u> </u>	J	٥	- C	1101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	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 NTESTINAL ACQUISITION	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0	0	o o		111. 00
113. 00 11300 NTEREST EXPENSE		Ŭ	Ö	Ĭ		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	11, 522	6, 240	2, 659, 245	100	125, 476, 514	
NONREI MBURSABLE COST CENTERS	11,022	0, 210	2,007,210	100	120, 170, 011	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	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 CENTERS	0	0	0	0		194. 00
194. 01 07951 PUBLIC RELATIONS	92	0	0	0		194. 01
194. 02 07952 MOB	0	0	0	0		194. 02
200.00 Cross Foot Adjustments	_			٦	_	200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	502, 377	2, 533, 426	272, 468	73, 902	373, 551	202. 00
Part I)		_, _,	,		2.2/22.	
203.00 Unit cost multiplier (Wkst. B, Part I)	43. 256156	405. 997756	0. 102461	739. 020000	0. 002977	203. 00
204.00 Cost to be allocated (per Wkst. B.	131, 297	142, 516	139, 939	37, 955	25, 202	204. 00
Part II)		·				
205.00 Unit cost multiplier (Wkst. B, Part	9. 237472	22. 839103	0. 052624	379. 550000	0. 000201	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)						

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES MONROE HOSPITAL In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 5/26/2019 12:54 pm Provider CCN: 15-0183 Peri od: From 01/01/2018 To 12/31/2018 Title XVIII Hospi tal PPS Costs Therapy Limit Total Costs Cost Center Description Total Cost RCE Total Costs

	Cost Center Description	(from Wkst. B, Part I, col.	Adj .	Total Costs	Di sal I owance	Total Costs	
		26)					
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	4, 792, 866		4, 792, 866	0	4, 792, 866	30. 00
31.00	03100 NTENSI VE CARE UNI T	2, 067, 791		2, 067, 791	0	2, 067, 791	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0		0	0	0	40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF	0		0	0	0	41.00
44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0			0	0	43. 00 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	4, 616, 274		4, 616, 274	0	4, 616, 274	50. 00
51. 00	05100 RECOVERY ROOM	0		0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2, 915, 981		2, 915, 981	0	0 2, 915, 981	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0		0	0	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	Ö	59. 00
60.00	06000 LABORATORY	2, 260, 730		2, 260, 730	0	2, 260, 730	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	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		0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	724 020		724 020	0	724 020	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	736, 030 196, 476	ł	736, 030 196, 476	0	736, 030 196, 476	
67. 00	06700 OCCUPATI ONAL THERAPY	0	l .	0	0	0	
68. 00	06800 SPEECH PATHOLOGY	0	O	0	0	0	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	427, 998		427, 998 0	0	427, 998 0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 237, 443		3, 237, 443	0	3, 237, 443	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 296, 536	l e	1, 296, 536	0	1, 296, 536	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 371, 524	l	1, 371, 524	0	1, 371, 524 0	
75. 00	07500 ASC (NON-DISTINCT PART)	0		0	0	Ö	
76. 98	07698 WOUND CARE	1, 084, 187	l	1, 084, 187	0	1, 084, 187	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0		0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	3, 817, 246		3, 817, 246	0	0 3, 817, 246	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,017,210		0,017,210			92. 00
04.00	OTHER REIMBURSABLE COST CENTERS				0		94. 00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	ŀ	0 0	0	0	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	97. 00
98. 00 99. 00	09900 CMHC	0			0	0	98. 00 99. 00
99. 10	09910 CORF	0		0		0	99. 10
	09911 CORF	0		0		0	
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0		0			100. 00 101. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0		0			105. 00 106. 00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0		0			106.00
108.00	10800 LUNG ACQUISITION	0		0		0	108. 00
	10900 PANCREAS ACQUISITION	0		0			109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0		0			110. 00 111. 00
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	<u> </u>	0	<u> </u>	1 0	115. 00

Health Financial Systems MONROE HOSP			OSPI	TAL	AL In Lieu of Form CMS-2552			2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0183		rom 01/01/2018 Worksheet C rom 01/01/2018 Part I To 12/31/2018 Date/Time Prej 5/26/2019 12:				
				Title	XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	The	erapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00		2.00	3.00	4. 00	5. 00	
116. 00 11600 200. 00 201. 00 202. 00	HOSPICE Subtotal (see instructions) Less Observation Beds Total (see instructions)	28, 821, 082 0 28, 821, 082		0	28, 821, 08 28, 821, 08	0	28, 821, 082	201. 00

Health Financial Systems

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

			20011		5/26/2019 12:	54 pm_
			e XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Charges Outpatient	Total (col 6	Cost or Other	TEFRA	
Cost Center Bescription	riipatrent	outputtent	+ col . 7)	Ratio	Inpati ent	
			,		Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 760, 436		5, 760, 436			30.00
31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	2, 568, 100		2, 568, 100			31. 00 32. 00
33. 00 03200 CORONART CARE UNIT	0					33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T				ó		34. 00
40. 00 04000 SUBPROVI DER - I PF	Ö					40. 00
41. 00 04100 SUBPROVI DER - RF	o					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
46.00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0)		46. 00
50. 00 05000 OPERATING ROOM	4, 359, 497	8, 114, 758	12, 474, 255	0. 370064	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0, 111, 700	12, 17 1, 200	0.000000	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	Ö	0			0. 000000	52. 00
53. 00 05300 ANESTHESI OLOGY	o	0	(0.000000	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 440, 340	22, 564, 122	25, 004, 462		0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0.000000	0. 000000	55. 00
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	0	0		0.000000	0.000000	56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000 0. 000000	0. 000000 0. 000000	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0. 000000	0. 000000	59.00
60. 00 06000 LABORATORY	3, 517, 409	15, 802, 031	19, 319, 440		0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	(0.000000	0. 000000	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	O	0	(0.000000	0. 000000	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0.000000	0.000000	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0. 000000	0. 000000	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	(0.000000	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	4, 112, 283	889, 986			0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	543, 426	41, 590	585, 016	0. 335847 0. 000000	0. 000000 0. 000000	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		0		0. 000000	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	760, 352	1, 826, 272	2, 586, 624		0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	, , , , ,	0. 000000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 981, 987	8, 021, 876			0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 472, 856	2, 652, 525			0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 652, 798	2, 045, 595	4, 698, 393		0. 000000	73. 00
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART)	0	0		0.000000	0.000000	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 98 07698 WOUND CARE	8, 260	4, 070, 781	4, 079, 041	0. 000000 0. 265795	0. 000000 0. 000000	75. 00 76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0, 200	4, 070, 701			0. 000000	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	()		89. 00
90. 00 09000 CLI NI C	0	0	(0. 000000	0. 000000	
91. 00 09100 EMERGENCY	2, 296, 344	18, 972, 890	1		0. 000000	91.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	l O	0		0.000000	0. 000000	92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	O	0		0. 000000	0. 000000	94. 00
95. 00 09500 AMBULANCE SERVI CES		0			0. 000000	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	Ö	0			0. 000000	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0. 000000	0.000000	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0. 000000	0.000000	98. 00
99. 00 09900 CMHC	0	0	()		99. 00
99. 10 09910 CORF	0	0				99. 10
99. 11 09911 CORF 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM	0	0				99. 11 100. 00
101.00 10100 HOME HEALTH AGENCY		0				100.00
SPECIAL PURPOSE COST CENTERS	u u			<u>' </u>		101.00
105. 00 10500 KIDNEY ACQUISITION	0	0	()		105. 00
106. 00 10600 HEART ACQUISITION	o	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	9			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE	ا	0	1	ή		111. 00 113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	О	0				115. 00
116. 00 11600 HOSPI CE	o	0				116. 00
	,					

Health Financial Systems	MONROE HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	Provider CCN: 15-0183		Worksheet C Part I	
				To 12/31/2018	Date/Time Pre 5/26/2019 12:	epared: 54 pm
		Title	XVIII	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	
200.00 Subtotal (see instructions)	40, 474, 088	85, 002, 426	125, 476, 51	4		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	40, 474, 088	85, 002, 426	125, 476, 51	4		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: 5/26/2019 12:54 pm | PPS | Health Financial Systems

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

					5/26/2019 12:54 pm
	Coot Contar Decement on	DDC Innotiont	Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31. 00
32.00	03200 CORONARY CARE UNIT				32. 00
33.00	03300 BURN INTENSIVE CARE UNIT				33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40.00	04000 SUBPROVI DER - I PF				40.00
41.00	04100 SUBPROVI DER - I RF				41.00
43.00	04300 NURSERY				43. 00
44. 00	04400 SKILLED NURSING FACILITY				44. 00
45. 00	04500 NURSING FACILITY				45. 00
46. 00	04600 OTHER LONG TERM CARE				46. 00
	ANCI LLARY SERVI CE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 370064			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 55. 00	05400 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	0. 116618 0. 000000			54. 00 55. 00
56. 00	05600 RADI OLOGT - THERAPEUTI C	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. 117018			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	06500 RESPI RATORY THERAPY	0. 147139			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 335847			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. 165466			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 215774			71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 181960			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 291913			73. 00
74. 00	07400 RENAL DI ALYSI S	0. 000000			74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 98	07698 WOUND CARE	0. 265795			76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00	09000 CLINIC	0. 000000			90.00
91. 00		0. 179473			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	0.00000			72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95.00	09500 AMBULANCE SERVICES	0. 000000			95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
99. 00					99. 00
	09910 CORF				99. 10
	09911 CORF				99. 11
	10000 I &R SERVICES-NOT APPRVD PRGM				100. 00
101.00	10100 HOME HEALTH AGENCY				101. 00
405.00	SPECIAL PURPOSE COST CENTERS				105.00
	10500 KIDNEY ACQUISITION				105.00
	10600 HEART ACQUISITION				106.00
	10700 LIVER ACQUISITION				107. 00
	10800 LUNG ACQUISITION				108.00
	10900 PANCREAS ACQUISITION				109.00
	11000 INTESTINAL ACQUISITION				110.00
	11100 SLET ACQUISITION				111.00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF	1			113. 00 114. 00
		1			115.00
	111500 AMBULATURY SURGICAL CENTER (D. P.)	1			116. 00
200.00					200. 00
201.00					201. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	<u> </u>			1==::00

Health Financial Systems	MONROE HOSP	PI TAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0183	From 01/01/2018	Worksheet C Part I Date/Time Pre 5/26/2019 12:		
		Title XVIII	Hospi tal	PPS		
Cost Center Description	PPS Inpatient Ratio 11.00					
202.00 Total (see instructions)					202.00	

Hearth Frhancial Systems	MUNRUE HUSPITAL	In Lie	u 01 F01111 CWS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0183	Peri od:	Worksheet C
		From 01/01/2018	Part I
		To 12/31/2018	Date/Time Prepared:
			5/26/2019 12:54 pm

					0 12/31/2010	5/26/2019 12:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
-	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30.00	03000 ADULTS & PEDIATRICS	4, 792, 866		4, 792, 866		4, 792, 866	
31. 00 32. 00	03100 NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	2, 067, 791		2, 067, 791	0	2, 067, 791 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	Ö		Ö	0	Ö	34. 00
40. 00	04000 SUBPROVI DER - I PF	0		0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0		0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0		0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY				0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS			,	,		
50.00	05000 OPERATING ROOM	4, 616, 274		4, 616, 274	0	4, 616, 274	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0		ĺ	0	Ö	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 915, 981		2, 915, 981	0	2, 915, 981	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	0		0	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		ĺ	0	ő	59.00
60.00	06000 LABORATORY	2, 260, 730		2, 260, 730	0	2, 260, 730	60.00
60. 01	06001 BLOOD LABORATORY	0		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	0	0	61.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0		62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		ĺ	0	ő	64. 00
65.00	06500 RESPI RATORY THERAPY	736, 030	0	736, 030	0	736, 030	65. 00
66. 00	06600 PHYSI CAL THERAPY	196, 476	0	196, 476	0	196, 476	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	427, 998	0	427, 998	0	427, 998	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 237, 443		3, 237, 443		3, 237, 443	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 296, 536		1, 296, 536		1, 296, 536	1
73. 00 74. 00	07400 RENAL DIALYSIS	1, 371, 524		1, 371, 524	0	1, 371, 524 0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	Ö		Ö	0	Ö	75. 00
76. 98	07698 WOUND CARE	1, 084, 187		1, 084, 187	0	1, 084, 187	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0		0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ł .	Ö		ő	1
90.00	09000 CLI NI C	0		0	0	0	90. 00
91. 00	09100 EMERGENCY	3, 817, 246		3, 817, 246	0	3, 817, 246	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0		0		0	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0			0	0	94.00
95. 00	09500 AMBULANCE SERVICES	Ö	•	Ö	0	l	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0		0	0	0	1
98. 00 99. 00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0		0	0	0	98. 00 99. 00
	09910 CORF	0				0	
	09911 CORF	0		Ö		0	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	ł .	0		l	100. 00
101.00	10100 HOME HEALTH AGENCY	0		0		0	101. 00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0		T 0		0	105. 00
	10600 HEART ACQUISITION	0	ł				106.00
107.00	10700 LIVER ACQUISITION	0		0		0	107. 00
	10800 LUNG ACQUISITION	0		0		•	108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0				l	109. 00 110. 00
	TIOOO INTESTINAL ACQUISITION 11100 ISLET ACQUISITION					l	111.00
	11300 INTEREST EXPENSE			l			113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115. 00

Health Financial Systems MONROE HOS				TAL In Lieu of Form CMS-25			2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		F		Period: From 01/01/2018 To 12/31/2018				
				Ti tl	e XIX	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		rapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00		2. 00	3.00	4. 00	5. 00	
116. 00 11600 200. 00 201. 00 202. 00	HOSPICE Subtotal (see instructions) Less Observation Beds Total (see instructions)	28, 821, 082 0 28, 821, 082	ĺ	0	28, 821, 08 28, 821, 08	0	28, 821, 082	201. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/26/2019 12:54 pm Health Financial Systems

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

				Ti tl	e XIX	Hospi tal	5/26/2019 12: PPS	54 pm
				Charges			TEEDA	
		Cost Center Description	Inpatient	Outpati ent	lotal (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	
				7.00	ŕ		Rati o	
	I NPAT	TENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00		ADULTS & PEDIATRICS	5, 760, 436		5, 760, 436			30. 00
31.00		INTENSIVE CARE UNIT	2, 568, 100		2, 568, 100			31.00
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0)		32. 00 33. 00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	o o					34. 00
40.00		SUBPROVI DER - I PF	0		(40.00
41. 00 43. 00		SUBPROVI DER - I RF NURSERY	0)		41. 00 43. 00
44. 00		SKILLED NURSING FACILITY	O					44. 00
45. 00	04500	NURSING FACILITY	0		C)		45. 00
46. 00	ANCL I	OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0)		46. 00
50.00	05000	OPERATING ROOM	4, 359, 497	8, 114, 758	12, 474, 255	0. 370064	0. 000000	50. 00
51.00		RECOVERY ROOM	0	0	C		0. 000000	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
54. 00	1	RADI OLOGY-DI AGNOSTI C	2, 440, 340	22, 564, 122	25, 004, 462		0. 000000	
55. 00		RADI OLOGY-THERAPEUTI C	0	0	C	0. 000000	0. 000000	
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	0	(0. 000000 0. 000000	0. 000000 0. 000000	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	o	0		0.000000	0. 000000	
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	0	C	0. 000000	0. 000000	
60. 00 60. 01		LABORATORY BLOOD LABORATORY	3, 517, 409	15, 802, 031	19, 319, 440	0. 117018 0. 000000	0. 000000 0. 000000	
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000	0. 000000	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0. 000000	0. 000000	
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	(0.000000	0.000000	
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	4, 112, 283	889, 986	5, 002, 269	0. 000000 0. 147139	0. 000000 0. 000000	
66. 00		PHYSI CAL THERAPY	543, 426	41, 590			0. 000000	
67. 00		OCCUPATIONAL THERAPY	0	0	(0.00000	0.000000	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	760, 352	1, 826, 272	2, 586, 624	0. 000000 0. 165466	0. 000000 0. 000000	
70. 00		ELECTROENCEPHALOGRAPHY	0	0	2, 333, 32	0. 000000	0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 981, 987	8, 021, 876			0. 000000	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	4, 472, 856 2, 652, 798	2, 652, 525 2, 045, 595			0. 000000 0. 000000	
74.00		RENAL DIALYSIS	2,032,740	2, 043, 343	_		0. 000000	
75. 00		ASC (NON-DISTINCT PART)	O	0	1	0.00000	0. 000000	
76. 98 77. 00		WOUND CARE ALLOGENEIC STEM CELL ACQUISITION	8, 260	4, 070, 781 0			0. 000000 0. 000000	
77.00		TIENT SERVICE COST CENTERS	<u> </u>	0		0.00000	0.000000	77.00
88. 00	1	RURAL HEALTH CLINIC	0	0			0. 000000	
89. 00 90. 00	1	FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
91.00	1	EMERGENCY	2, 296, 344	18, 972, 890	21, 269, 234		0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	0. 000000	0. 000000	92.00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS		0		0. 000000	0.000000	94. 00
95.00	1	AMBULANCE SERVICES	0	0		0.000000	0. 000000	
96. 00	1	DURABLE MEDICAL EQUIP-RENTED	O	0	C	0. 000000	0. 000000	1
97. 00 98. 00		DURABLE MEDICAL EQUIP-SOLD	0	0	(0. 000000 0. 000000	0. 000000 0. 000000	
98.00	09900	OTHER REIMBURSABLE COST CENTERS	0	0		0.000000	0.00000	98. 00 99. 00
99. 10	09910	CORF	O	0	d			99. 10
99. 11	1	•	0	0				99. 11
		I&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY	0	0				100. 00 101. 00
101.00		AL PURPOSE COST CENTERS	<u> </u>					101.00
	1	KIDNEY ACQUISITION	0	0	•			105.00
	1	HEART ACQUISITION LIVER ACQUISITION	0	0				106. 00 107. 00
	1	LUNG ACQUISITION	o o	Ö	1			108. 00
109.00	10900	PANCREAS ACQUISITION	0	0	(109. 00
		INTESTINAL ACQUISITION ISLET ACQUISITION	0	0	0			110. 00 111. 00
		INTEREST EXPENSE		0		1		113.00
114.00	11400	UTILIZATION REVIEW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	0	•			115.00
110.00	111000	HOSPI CE	0	0	(<u>'</u>	1	116. 00

Health Financial Systems	MONROE HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 01/01/2018	Worksheet C Part I		
				To 12/31/2018	Date/Time Pre 5/26/2019 12:	epared: 54 pm	
		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		
200.00 Subtotal (see instructions)	40, 474, 088	85, 002, 426	125, 476, 51	4		200.00	
201.00 Less Observation Beds						201. 00	
202.00 Total (see instructions)	40, 474, 088	85, 002, 426	125, 476, 51	4		202. 00	

Per Impart Impa						5/26/2019 12:54 pm
NAME NOT THE SAMPLE CODE CENTERS 11.00 10.00 1		Cook Cooker Doorsinking	DDC 1+i+	Title XIX	Hospi tal	PPS
INVALIDATION SAMPLE COST CENTERS 11.00		Cost Center Description				
THE PART IN SOUTH SENDING COST CERTIFIES 3.0 0.0 0.0000 AUXILYS A PERI ARTS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS A PERI ARTS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS A PERI ARTS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.1 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.0 0.0 0.0 0.0000 AUXILYS AS A COST OF THE STATE 3.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0						
31.00 30100 INTENSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS				
32.00		1				30. 00
33.00 03000 BURN INTERSIVE CARE UNIT 33.00 40.00 03000 BURN INTERSIVE CARE UNIT 34.00 03000 BURN INTERSIVE CARE UNIT 34.00 03000 BURN INTERSIVE CARE UNIT 34.00 04.00 04.000 BURN INTERSIVE CARE UNIT 34.00 04.000 BURN CARE PRES 34.00 04.000 BURN CARE PRES 34.00 04.000 BURNESPY 34.000 34.000 BURNESPY 34.000 BURNES		1				
34.00 30.400 SURGICAL INTERSIVE CARE UNIT 40.00		1				
40.00 0.000 SUBPROVIDER - 1 PF						
41.00 01100 SURPROVIDER - 1 IRF 41.00 44.00						
43.00 3400 MIRSTRY						
44.00 04.0						
46. 00 AGOU OTHER LORN TERM CARE 46. 00 AGOU OTHER LORN TERM CARE 50. 00 GOOD OF PEAN IN BROOM 0. 000000 51. 00 50. 00						
MICHELARY SERVICE COST CAPITIES	45.00					45. 00
	46.00	04600 OTHER LONG TERM CARE				46. 00
51.00 51.00 FCOVERY RODM & LABOR ROOM 0.000000 55.00						
52.00 5200 DELIVERY RODM & LABOR RODM 0.0000000 53.0			1			
53.00 03.00 ANESTHESI OLOGY 0.000000 55.00		1	1			
94.00 0-400 RADI CLORY-HIARDSTIC 0.116-18 9-5.00 0-500 0		1	1			
55.00 05500 RADI CLIGAY - THERAPEUTI C		1 1	1 1			
56.00 05600 RADIO ISTORPE 0.000000 55.00 5		1 1	1 1			
57.00 05700 CT SCAN 0.000000 55.00 05900		1 1	1			
99.00 05900 CARDIAC CATHETER ZATION 0.000000 59.00 0.000000 0.0000000 0.0000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000	57.00	1 1	1 1			
60.00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1 1			58. 00
0.00 0.000 0.000 0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
1.1 00 06-10.0 PBP CLINI CAL LAB SERVI CES-PROM ONLY 0.0000000 0.0000000 0.63.0 0 0.63.00 0.63.00 0.63.00 0.63.00 0.63.00 0.63.00 0.63.00 0.63.00 0.63.00 0.63.00 0.63.00 0.65.00		1 1	1			
		1	1			
63.00 06.300 06.000 STORI NG, PROCESSI NG & TRANS. 0.000000 06.40, 00 06.40, 00 06.40, 00 06.50, 00 07.50,			1			
44. 00 0.6400 INTRAVENOUS THERAPY 0.000000 0.650 0			1			l l
65. 00 06.500 RASDI RATORY THERAPY 0. 147139 0. 60. 00 06. 00 06.00 06.00 06.00 07. 00 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.0000 0. 06.70 0. 00.00000 0. 00.00000 0. 00.00000 0. 00.00000 0. 00.00000 0. 00.00000 0. 00.00000 0.		l l	1			
66.00 0.6600 PHYSI CAL THERAPY 0.335847 0.6.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.68.00 0.6800 0.6800 0.6800 0.6800 0.6800 0.6900 ELECTROCASIDI OLOGY 0.000000 0.165466 0.69.00 0.000000 0.165406 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1	1			
67.00 0c700 0c700 0c000 0c0000 0c00000 0c000000 0c00000 0c00000 0c000000 0c000000 0c000000 0c000000 0c00000 0c00000 0c00000 0c00000 0c00000 0c00000 0c000000 0c00000 0c00000 0c00000 0c00000 0c00000 0c00000 0c000000 0c00000 0c000000 0c0000000 0c0000000 0c000000 0c000000 0c000000 0c0000000 0c00000000			1			
68. 00 0.6800 SPECCH PATHOLOGY 0.000000 6.8 0.00 0.00000 0.70 0.00 0.0			1			
70. 00 07000 07000 07000 07000 07000 07000 071			1			
17.1 00 07.100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 181960 72.00 72.00 72.00 MPL DeV CHARGED TO PATIENTS 0. 181960 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 75.	69.00	06900 ELECTROCARDI OLOGY	0. 165466			69. 00
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0. 181960 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 291913 73. 00 07400 RENAL DIALYSIS 0. 000000 75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 00 07500 ASC (NON-DISTINCT PART) 0. 0000000 75. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 0000000 0. 265795 75. 00 0. 00000000	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70. 00
73.00 07300 DRICS CHARGED TO PATLENTS 0.291913 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 75.00			0. 215774			
74. 00			1			
75. 00 07500 ASSC (NON-DISTINCT PART) 0. 0.000000 75. 00 07698 WOUND CARE 0. 265795 76. 98 07698 WOUND CARE 0. 265795 76. 98 07698 WOUND CARE 0. 0. 0000000 77. 00 0000000 77. 00 0000000 77. 00 0000000 77. 00 0000000 77. 00 0000000 88. 00 088. 00 08900 FEDERALLY COST CENTERS 0. 0.000000 89. 00 09000 CLINIC COST CENTERS 0. 0.000000 99. 00 09000 CLINIC COST CENTERS 0. 0. 000000 99. 00 09000 CLINIC COST CENTERS 0. 0. 000000 99. 00 09000 CLINIC COST CENTERS 0. 0. 000000 99. 00 09000 CLINIC COST CENTERS 0. 0. 000000 99. 00 09000 CLINIC COST CENTERS 0. 0. 000000 99. 00 09000 CLINIC COST CENTERS 0. 0. 000000 99. 00 0900 CLINIC CENTERS 0. 0. 0000000 99. 00 0900 CLINIC CENTERS 0. 0. 000000 99. 00 0900 CLINIC CENTER 0. 0. 000000 99. 00 0900 CLINIC CENTER 0. 0. 000000 99. 00 0900 CLINIC CENTER 0. 0. 000000 99. 00 0900 CLINIC CENTER 0. 0. 000000 99. 00 0900 CLINIC CENTER 0. 0. 000000 99. 00 0900 CLINIC CENTER 0. 0. 000000 99.			1			
76. 98 07598 MOUND CARE 0. 265795 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0. 000000 77. 00 000000 00000 00000 000000 889. 00 98. 00 08800 RURAL HEALTH CLINI C 0. 000000 89. 00 99. 00 09000 CLINI C 0. 000000 99. 00 91. 00 09100 00000 00000 000000 000000 99. 00 92. 00 09200 000000 000000 000000 99. 00 00000 00000 000000 000000 000000			1			
77.00 07700 01700 011000 01150 011			1			
Name		1	1			
88. 00 08800 RURAL HEALTH CLINIC 0. 000000 89. 00 99. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 99. 00 99.		OUTPATIENT SERVICE COST CENTERS				
90. 00 090.00 CLI NI C 0.000000 91. 00 0.179473 91. 00 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 92. 00 0.000000 93. 00 0.0000000 93. 00 0.0000000 93. 00 0.00000000 93. 00 0.000000000 93. 00 0.000000000 93. 00 0.000000000000000000000000000000	88. 00		0. 000000			88. 00
91. 00 09100 EMERGENCY 0. 179473 0. 000000 092.00 0BSERVATION BEDS (NON-DISTINCT PART) 0. 0000000 092.00 0BSERVBURSABLE COST CENTERS 92. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 94. 00 95. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00 09600 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 99. 00 09700 09700 098. 00 09900 CMPIC 099. 00 099. 00 09900 CMPIC 099. 00 099. 00 099. 00 09900 CMPIC 099. 00 099. 0	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 0THER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0.000000 95. 00 99500 AMBULANCE SERVI CES 0.000000 95. 00 99600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09900 CMHC 99. 00 99900 CMHC 99. 00 99900 CMHC 99. 10 09910 CORF 99. 11 09911 CORF 99. 11 00001 RR SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 10100 HOME HEALTH AGENCY 101. 00 10500 KI DNEY ACQUI SITI ON 105. 00 10500 KI DNEY ACQUI SITI ON 107. 00 10700 LI VER ACQUI SITI ON 108. 00 10900 DANCREAS ACQUI SITI ON 109. 00 10900 INTESTI NAL ACQUI SITI ON 109. 00 111. 00 11100 INTEREST EXPENSE 115. 00 11500 INTEREST EXPENSE 116. 00 11600 INTEREST EXPENSE 115. 00 11500 INTEREST EXPENSE 116. 00 116. 00 11600 INTEREST EXPENSE 115. 00 11500 INTEREST EXPENSE 115. 00 116. 00 11600 INTEREST EXPENSE 116. 00 116. 00 11600 INTEREST EXPENSE 115. 00 116. 00 11600 INTEREST EXPENSE 115. 00 116. 00 11600 INTEREST EXPENSE 116. 00 116. 00 11600 INTEREST EXPENSE 116. 00 116. 00 11600 INTEREST EXPENSE 116. 00 116. 00 INTEREST EXPENSE 116. 00 INTEREST EXPENSE 116. 00 INTEREST EXPENSE 116. 00 INTEREST EXPENSE INTERE						
OTHER REIMBURSABLE COST CENTERS 94.00 94.00 109			1 1			
94. 00 09400 HOME PROGRAM DI ALYSI S 0.000000 95. 00 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98. 00 99. 00 09900 CMHC 99. 10 09910 CORF 99. 11 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 100. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 10500 LUNG ACQUI SI TI ON 107. 00 10700 LUNG ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 110. 00 11000 11000 SLET ACQUI SI TI ON 109. 00 110. 00 11000 11000 SLET ACQUI SI TI ON 111. 00 11100 11001 SLET ACQUI SI TI ON 111. 00 11100 11100 SLET ACQUI SI TI ON 111. 00 11100 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 11500 11500 MBULATORY SURGI CAL CENTER (D. P.) 115. 00 11500 MBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE	92. 00	. ,	0. 000000			92. 00
95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 96. 00 96. 00 97. 00	04.00		0.000000			94.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 99. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09910 CORF 99. 10 09911 CORF 99. 11 09911 CORF 99. 11 00901 ER SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 10100 HOME HEALTH AGENCY 101. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 10900 PANCREAS ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10000 INTERSTI NAL ACQUI SI TI ON 101. 00 11100 SLET ACQUI SI TI ON 111. 00 11100 SLET ACQUI SI TI ON 111. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11500 HOSPI CE 116. 00		1				
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 00 99. 00 09900 CMHC 99. 10 99. 10 09910 CORF 99. 11 09911 CORF 99. 11 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10700 LI VER ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 110. 00 11100 INTERSTI NAL ACQUI SI TI ON 109. 00 111. 00 11100 INTERSTI NAL ACQUI SI TI ON 111. 00 111. 00 111. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 HOSPI CE 116. 00		1	1			
98. 00		1	1			
99. 10						ı
99. 11 100. 00 10000 &R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTERST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 116. 00 11600 HOSPI CE	99. 00	09900 CMHC				99. 00
100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 10800 LUNG ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 1000 INTESTI NAL ACQUI SI TI ON 109. 00 110. 00 INTESTI NAL ACQUI SI TI ON 110. 00 111. 00 111. 00 111. 00 113. 00 INTERST EXPENSE 113. 00 114. 00 UTI LI ZATI ON REVI EW-SNF 115. 00 115. 00 115. 00 MBULATORY SURGI CAL CENTER (D. P.) 116. 00 116. 00 1000 HOSPI CE 116. 00 116. 00 116. 00 1000 HOSPI CE 116. 00						
101. 00 10100 HOME HEALTH AGENCY						
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 106. 00 10600 HEART ACQUI SI TI ON 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 110. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 116. 00						
105. 00 106.00 106.00 106.00 107. 00 107. 00 107. 00 108. 00 108. 00 108. 00 109. 00 1	101.00					101.00
106. 00	105.00					105.00
107. 00						
108. 00						
109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 110. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 100 HOSPI CE 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 1100 100						
110. 00						
111. 00 11100 I SLET ACQUI SI TI ON 111. 00 113. 00 113. 00 11300 I NTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 116. 00 11600 HOSPI CE 116. 00 116. 00 11600 1100 1		1				
113. 00						
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 11600 HOSPI CE 116. 00		1 1				
116. 00 11600 HOSPI CE 116. 00		1 1				
		1 1				
700 000 NUNTOTAL (COD LINSTRUCTIONS) 1000 00		l i				
200. 00 Subtotal (see First detroits) 201. 00 Less Observation Beds 201. 00		,				200. 00
201. 00 10.33 00.361 Vati 011 Deta3	201.00	Less observation beds	1			J201. 00

Heal th Financi	al Systems	MONROE HOS	SPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF	F RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0183	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/26/2019 12:	
			Title XIX	Hospi tal	PPS	
Co	ost Center Description	PPS Inpatient Ratio 11.00				
202. 00 To	otal (see instructions)					202.00

Heal th Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

				12, 01, 2010	5/26/2019 12:	54 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cost		Operating Cost	
	, ·		Net of Capital	Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
	1.00	2.00	col. 2) 3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	4, 616, 274	719, 919	3, 896, 355	0	0	50. 00
51. 00 05100 RECOVERY ROOM	0	0	0	Ö	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	o	Ö	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 915, 981	493, 610	2, 422, 371	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	56.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (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	2, 260, 730	200, 695	2, 060, 035	0	0	60. 00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	70, 000	0	(70 544	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	736, 030	1		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	196, 476	7, 132	189, 344	0	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00
	427 000	15 (7)	412 224	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	427, 998	15, 672	412, 326	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 237, 443	104 727	2 040 714	0	0	70. 00 71. 00
72. 00 07/200 IMPL. DEV. CHARGED TO PATIENTS	1, 296, 536			0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 371, 524	83, 621 82, 943		0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	1, 371, 324	02, 743	1, 200, 301	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 98 07698 WOUND CARE	1, 084, 187	255, 891	828, 296	0	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	020, 270	Ö	0	77. 00
OUTPATIENT SERVICE COST CENTERS	-		-1			
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	0	0	0	0	90.00
91. 00 09100 EMERGENCY	3, 817, 246	442, 849	3, 374, 397	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	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
99. 11 09911 CORF	0	0	0	0	0	99. 11
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	l .		0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION		l .	_	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0		0	0		100.00
108. 00 10800 LUNG ACQUISITION		·	Ö	0		107. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 NTESTINAL ACQUISITION	0	l	0	ol		110. 00
111. 00 11100 SLET ACQUISITION	0	l	0	ol		111. 00
113. 00 11300 NTEREST EXPENSE				ا	Ü	113. 00
114.00 11400 UTILIZATION REVIEW-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		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	21, 960, 425	2, 555, 548	19, 404, 877	o		200. 00
201.00 Less Observation Beds	0	0	0	0		201. 00
202.00 Total (line 200 minus line 201)	21, 960, 425	2, 555, 548	19, 404, 877	0	0	202. 00

Period: Worksheet C From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm REDUCTIONS FOR MEDICALD ONLY

					5/26/2019 12:	54 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	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	•					
50. 00 05000 OPERATI NG ROOM	4, 616, 274	12, 474, 255	0. 370064			50.00
51.00 05100 RECOVERY ROOM	0		1			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l c				52.00
53. 00 05300 ANESTHESI OLOGY	0		0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 915, 981	25, 004, 462				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 713, 701	25,004,402	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0		0.00000			•
	0					56.00
57. 00 05700 CT SCAN	0		0.000000			57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.000000			59. 00
60. 00 06000 LABORATORY	2, 260, 730	19, 319, 440				60. 00
60. 01 06001 BLOOD LABORATORY	0	C	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0.000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0.000000			63.00
64.00 06400 INTRAVENOUS THERAPY	0	C	0.000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	736, 030	5, 002, 269	0. 147139			65. 00
66. 00 06600 PHYSI CAL THERAPY	196, 476					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67. 00
68. 00 06800 SPEECH PATHOLOGY			0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	427, 998	2 504 424	1			69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	427, 990	2, 586, 624				1
	0 007 440	45 000 0/0	0.000000			70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3, 237, 443					71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	1, 296, 536					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 371, 524					73. 00
74. 00 07400 RENAL DIALYSIS	0	(C	0. 000000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	0. 000000			75. 00
76. 98 07698 WOUND CARE	1, 084, 187	4, 079, 041	0. 265795			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	0.000000			90.00
91. 00 09100 EMERGENCY	3, 817, 246	21, 269, 234	0. 179473			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS		_				
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0. 000000			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			1			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0.000000			98. 00
99. 00 09900 CMHC	0					99.00
	0		0.000000			
99. 10 09910 CORF	0	C				99. 10
99. 11 09911 CORF	0	C	1 1111111			99. 11
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0					100.00
101.00 10100 HOME HEALTH AGENCY	0	<u>C</u>	0.000000			101. 00
SPECIAL PURPOSE COST CENTERS			,			
105.00 10500 KIDNEY ACQUISITION	0					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 NTESTI NAL ACQUI SI TI ON	1 0	i c	0. 000000			110.00
111. 00 11100 SLET ACQUI SI TI ON	0	l c	0. 000000			111.00
113. 00 11300 NTEREST EXPENSE			3. 500000			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	1					114. 00
115. OO 11500 AMBULATORY SURGICAL CENTER (D. P.)	_		0. 000000			115. 00
116. 00 11600 HOSPI CE			0.00000			
	21 0/2 125	117 147 070				116. 00
200.00 Subtotal (sum of lines 50 thru 199)	21, 960, 425	117, 147, 978				200. 00
201.00 Less Observation Beds	01 0/0 /05	117 117 070	(201. 00
202.00 Total (line 200 minus line 201)	21, 960, 425	117, 147, 978	il .			202. 00

Health Financial Systems	MONROE HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provi der C	Provider CCN: 15-0183		Worksheet D Part I Date/Time Prepared: 5/26/2019 12:54 pm	
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B, Part II, col. 26)	raj astmort	Related Cost (col. 1 - col 2)	:	0 / 001. 1)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDI ATRI CS	673, 046	0	673, 04	16 3, 209	209. 74	30.00
31. 00 INTENSIVE CARE UNIT	326, 297		326, 29		318. 03	
32. 00 CORONARY CARE UNIT	020,277		020, 2	0 1,020	0.00	
33. 00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	
40. 00 SUBPROVI DER - I PF	0	o	,	0 0	0.00	
41. 00 SUBPROVI DER - I RF	0	Ö	,	0 0	0.00	
43. 00 NURSERY	0			0 0	0.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
45. 00 NURSING FACILITY	0			0 0	0.00	
200.00 Total (lines 30 through 199)	999, 343		999, 34	4, 235		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.070					
30. 00 ADULTS & PEDIATRICS	2, 279	477, 997				30.00
31. 00 INTENSIVE CARE UNIT	199	63, 288	1			31.00
32. 00 CORONARY CARE UNIT	0	0				32.00
33. 00 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 SUBPROVI DER - I PF 41. 00 SUBPROVI DER - I RF						40.00
43. 00 NURSERY						43.00
44.00 SKILLED NURSING FACILITY						44. 00
45. 00 NURSING FACILITY						45. 00
200.00 Total (lines 30 through 199)	2, 478	۳	1			200.00
200. 00 10 tal (111163 30 till ough 177)	2,470	341, 200	T .			1200.00

Health Financial Systems MONROE HOSPITAL In Lieu					u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der CO	CN: 15-0183	Peri od:	Worksheet D	
				From 01/01/2018	Part II	
				To 12/31/2018	Date/Time Pre	pared:
		T: +1 o	: XVIII	Hooni tol	5/26/2019 12: PPS	54 pm
Coat Contar Decement on	Coni tal			Hospi tal		
Cost Center Description	Capi tal	Total Charges (from Wkst. C,			Capital Costs	
	(from Wkst. B,			Program	(column 3 x	
		Part I, col.	1,	. 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	5.00	
50. 00 05000 OPERATING ROOM	719, 919	12, 474, 255	0. 0577	12 3, 441, 755	198, 631	50.00
	/19,919	1	l .		•	
51. 00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	493, 610	25, 004, 462	l .		47, 066	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	200, 695	19, 319, 440	0. 01038	38 2, 757, 287	28, 643	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	00	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	00 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY	56, 489	5, 002, 269			32, 323	65. 00
66. 00 06600 PHYSI CAL THERAPY	7, 132				4, 744	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	l o	0. 00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	15, 672	2, 586, 624			4, 252	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 072	2, 300, 024	0. 00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	196, 727	15, 003, 863			53, 078	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	83, 621	7, 125, 381	0. 0131		32, 098	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	82, 943				34, 356	73.00
74. 00 07400 RENAL DIALYSIS	02, 743	4,070,373	0.00000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0	0.00000		0	75.00
76. 98 07698 WOUND CARE	255, 891	4, 079, 041			0	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	255, 691				0	77.00
OUTPATIENT SERVICE COST CENTERS	0	U	0.00000	0	U	77.00
88. 00 08800 RURAL HEALTH CLINIC		0	0.00000	00 0	0	00 00
	0		l .			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90. 00 09000 CLI NI C	0	0	0.0000		0	90.00
91. 00 09100 EMERGENCY	442, 849	1			22, 636	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.00000	00 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	00	0	
95. 00 09500 AMBULANCE SERVICES						95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000		0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000	00	0	98. 00
200.00 Total (lines 50 through 199)	2, 555, 548	117, 147, 978		22, 352, 827	457, 827	200. 00

Health Financial Systems	MONROE HO	OSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA			CN: 15-0183	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Pre 5/26/2019 12:	pared: 54 pm
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Nursing School	Nursing School	Allied Healt	n Allied Health	All Other	
	Post-Stepdown	_	Post-Stepdow	n Cost	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	_	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0		31.00
32. 00 03200 CORONARY CARE UNIT	0	0		0	_	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0	_	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0	0		0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0		0		44. 00
45. 00 04500 NURSING FACILITY	0	0		0		45. 00
200.00 Total (lines 30 through 199)	Swi ng-Bed	Total Costs	Total Dotion	t Per Diem (col.	Inpati ent	200. 00
Cost Center Description	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	3 ÷ COI. 0)	Frogram Days	
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	3, 20	0.00	2, 279	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 02	0.00	199	31. 00
32. 00 03200 CORONARY CARE UNIT		0		0.00	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00	0	34.00
40. 00 04000 SUBPROVI DER - I 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		0.00		43.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00		44. 00
45.00 04500 NURSING FACILITY		0		0.00		45. 00
200.00 Total (lines 30 through 199)		0	4, 23	5	2, 478	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	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 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm THROUGH COSTS

						5/26/2019 12: !	54 pm_
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi na School	Nursi na School	Allied Health	Allied Health	
	'		Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			2.00	071	0.00	
50. 00	05000 OPERATING ROOM		0		0	0	50.00
51. 00	05100 RECOVERY ROOM						51.00
	1					-	
52. 00	05200 DELIVERY ROOM & LABOR ROOM			1	0	0	52. 00
53.00	05300 ANESTHESI OLOGY		1) 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0	(0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	0	(0	0	55. 00
56.00	05600 RADI 01 SOTOPE	C	0	(0	0	56.00
57.00	05700 CT SCAN		0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		0	0	59. 00
60.00	06000 LABORATORY					0	60.00
60. 01	06001 BLOOD LABORATORY					0	60. 01
	1		1		,	١	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			(_	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	C	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	C	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	C	0	(0	0	67. 00
68.00	06800 SPEECH PATHOLOGY		0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY		0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY				0	ol	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	o	71. 00
72. 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	75. 00
76. 98	07698 WOUND CARE			(0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	(0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	_	_	1		_	
88. 00	08800 RURAL HEALTH CLINIC		0			-	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	(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 DIALYSIS	C	C	(0	0	94.00
95. 00	09500 AMBULANCE SERVI CES]	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD					0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS					0	98. 00
200.00							200.00
200.00	1 Total (Tilles 30 till bugli 177)	1	1	1	,	ا	₁ 200.00

11111000	11 00313				To 12/31/2018	Date/Time Pre 5/26/2019 12:	
			Title	e XVIII	Hospi tal	PPS	54 piii
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
	I	4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			.1			
50.00	05000 OPERATI NG ROOM	0	0	1	0 12, 474, 255	0.000000	
51.00	05100 RECOVERY ROOM	0	0	1	0	0.000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0.000000	
53. 00	05300 ANESTHESI OLOGY	0	0	(0 25 004 4/2	0.000000	
54. 00 55. 00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 25, 004, 462	0.000000	
	O5500 RADI OLOGY - THERAPEUTI C	0	0		0	0.000000	1
56. 00 57. 00	05600	0	0		0	0. 000000 0. 000000	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0.00000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		0	0.00000	1
60. 00	06000 LABORATORY	0	0		0 19, 319, 440		
60. 01	06001 BLOOD LABORATORY	0	0		n 17, 317, 440	0.00000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1	0	0.00000	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0.00000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0			0. 000000	
65. 00	06500 RESPIRATORY THERAPY	0	0		5, 002, 269		1
66. 00	06600 PHYSI CAL THERAPY	0	0		0 585, 016	0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 000,010	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	Ö		0 0	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	2, 586, 624	0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 15, 003, 863	0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 7, 125, 381	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 698, 393	0. 000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0.000000	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0.000000	75. 00
76. 98	07698 WOUND CARE	0	0		0 4, 079, 041	0.000000	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00
90.00	09000 CLI NI C	0	0		0	0.000000	90. 00
91. 00	09100 EMERGENCY	0	0		0 21, 269, 234	0. 000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0 0	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0)	0	0. 000000	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0)	0	0. 000000	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0)	0	0. 000000	1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0. 000000	
200.00	Total (lines 50 through 199)	0	0)	0 117, 147, 978		200. 00

Heal th Financial	Systems		MONROE HOSPI	TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF	I NPATI ENT/OUTPATI ENT	ANCI LLARY SERVI	ICE OTHER PASS	Provi der CCN: 15-0183	Peri od:	Worksheet D
THROUGH COSTS					From 01/01/2018	Part IV

HROUGH COSTS			Fr		Part IV Date/Time Prepared: 5/26/2019 12:54 pm	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
ANOLILIA DIVI OFFICIA DE CONT. OFFITEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000	0 444 755	1 0	0.007.000		F0 00
50. 00 05000 OPERATING ROOM	0.000000	3, 441, 755	i e	3, 037, 298	0	50.00
51. 00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0.000000	2 204 144		4 022 122	0	53. 00 54. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0.000000	2, 384, 166	0	6, 022, 132	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0. 000000 0. 000000	0	0	0	0	55. 00 56. 00
57. 00 05700 CT SCAN	0. 000000	0	0	0	0	57.00
· · · · · · · · · · · · · · · · · · ·	0. 000000	0		0	0	58.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59.00
60. 00 06000 CARDIAC CATHETERIZATION	0. 000000	2, 757, 287	0	1, 218, 127	0	60.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0. 000000	2, 131, 201	0	1, 210, 127	0	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	U	0	U	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0.000000	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2 042 241		385, 986	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 862, 241 389, 115		271	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	307, 113			0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	701, 842		499, 591	0	69.00
70. 00 07000 ELECTROCARD OLOGT	0. 000000	701, 042 0	0	477, 371	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 048, 069	1	2, 643, 812	Ö	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 734, 979	•	677, 049	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 946, 191	0	1, 577, 420	ő	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 710, 171	0	1, 5,7, 120	ő	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	Ö	75. 00
76. 98 07698 WOUND CARE	0. 000000	0	0	300, 994	Ö	76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0		0	77. 00
OUTPATIENT SERVICE COST CENTERS				-		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 087, 182	0	4, 003, 474	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	0	0	0	98. 00
200.00 Total (lines 50 through 199)		22, 352, 827	0	20, 366, 154	0	200. 00

Health Financial Systems MONROE HAPPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0183

				1	0 12/31/2016	5/26/2019 12:	
			Title	XVIII	Hospi tal	PPS	<u></u>
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11.011)	
		Part I, col. 9	1113117	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1, 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 370064	3, 037, 298	0	0	1, 123, 995	50. 00
51.00	05100 RECOVERY ROOM	0. 000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 116618	6, 022, 132	0	0	702, 289	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0, 122, 102		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		-	0	56.00
57. 00	05700 CT SCAN	0. 000000	0	·		0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0			0	58.00
59. 00	05900 CARDIAC CATHETERIZATION	0. 000000	0			0	59.00
60.00	06000 LABORATORY	1	_		-	_	
		0. 117018	1, 218, 127	1	-	142, 543	1
60. 01	06001 BLOOD LABORATORY	0. 000000	0	0		0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		1	-		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	1	-	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0			0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	1	-	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 147139	385, 986		-	56, 794	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 335847	271	0		91	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	1	-	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	0		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 165466	499, 591	0		82, 665	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 215774	2, 643, 812	553	0	570, 466	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 181960	677, 049	0	0	123, 196	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 291913	1, 577, 420	0	0	460, 469	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	0	75. 00
76. 98	07698 WOUND CARE	0. 265795	300, 994	0	0	80, 003	76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			•	<u> </u>		
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00	09000 CLI NI C	0. 000000	0	0	0	0	90.00
91. 00	09100 EMERGENCY	0. 179473	4, 003, 474			718, 515	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0			0	
72.00	OTHER REIMBURSABLE COST CENTERS	0.00000			<u> </u>		72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000		0			94. 00
95. 00	09500 AMBULANCE SERVI CES	0. 000000		ĺ			95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0			0	•
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0			0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0			0	98.00
200.00	1	0.000000	20, 366, 154	·	-	4, 061, 026	
200.00			20, 300, 154] 553		4, 001, 020	200.00
201.UL	Only Charges			l "	١		201.00
202.00			20 244 154	EE-3	0	4 041 024	202 00
202.00	Net Charges (line 200 - line 201)	1	20, 366, 154	553	ı Y	4, 061, 026	1202. UU

Health Financial Systems MONROE HAPPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST MONROE HOSPITAL Provi der CCN: 15-0183

				5/26/2019 12:54 pm
		Title XVIII	Hospi tal	PPS
	Costs			
Cost Center Description	Cost	Cost		
		Reimbursed		
		ervi ces Not		
		Subject To		
	,	,		
		ed. & Coins.		
		(see inst.)		
	6. 00	7. 00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	l ol	O		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0		54.00
		0		
55. 00 05500 RADI OLOGY-THERAPEUTI C	1 "	٩		55. 00
56. 00 05600 RADI OI SOTOPE	0	0		56. 00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60. 00 06000 LABORATORY	l ol	o		60.00
60. 01 06001 BLOOD LABORATORY	0	0		60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	l o	9		61. 00
		0		62. 00
	-1	- 1		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	O	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	l ol	o		67. 00
68. 00 06800 SPEECH PATHOLOGY		0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	l ol	0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		Ö		70.00
	1	0		
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	119	-1		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	O		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	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	o	0		76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	l ol	О		77. 00
OUTPATIENT SERVICE COST CENTERS	,			
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0		89. 00
	1			•
90. 00 09000 CLI NI C	0	O		90. 00
91. 00 09100 EMERGENCY	0	0		91. 00
92.00 O9200 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	l ol	İ		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0		98.00
	1	-1		
200.00 Subtotal (see instructions)	119	0		200. 00
201.00 Less PBP Clinic Lab. Services-Program	0			201. 00
Only Charges				
202.00 Net Charges (line 200 - line 201)	119	0		202. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	MONROE HO	Provi der C		In Lie Period: From 01/01/2018 To 12/31/2018	u of Form CMS-2552-10 Worksheet D Part I Date/Time Prepared: 5/26/2019 12:54 pm	
		Ti tl	Title XIX		PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capi tal Rel ated 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	1					
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT	673, 046 326, 297	0	673, 0 ⁴ 326, 29		209. 74 318. 03	
32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT	0			0 0	0. 00 0. 00	
34.00 SURGICAL INTENSIVE CARE UNIT	0				0.00	
40. 00 SUBPROVI DER - I PF	0	0			0.00	
41. 00 SUBPROVI DER - I RF	0	0		0 0	0.00	41. 00
43. 00 NURSERY	0			0 0	0.00	
44.00 SKILLED NURSING FACILITY	0			0	0.00	1
45. 00 NURSING FACILITY	0			0 0	0. 00	
200.00 Total (lines 30 through 199) Cost Center Description	999, 343 I npati ent	I npati ent	999, 34	4, 235		200. 00
cost center bescription	Program days	Program				
	110graiii days	Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	26					30.00
31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT	5	1, 590 0	1			31. 00 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	Ö				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	7 043	1			45. 00
200.00 Total (lines 30 through 199)	31	7, 043	Pl			200. 00

Health Financial Systems	MONROE HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0183	Peri od:	Worksheet D	
				From 01/01/2018	Part II	
				To 12/31/2018	Date/Time Pre 5/26/2019 12:	pared:
		Ti ti	e XIX	Hospi tal	PPS	34 piii
Cost Center Description	Capi tal	Total Charges			Capital Costs	
obst contest baser per an	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.			column 4)	
	Part II, col.	8)	2)		,	
	26)	,	ĺ			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		Г	T			
50. 00 05000 OPERATI NG ROOM	719, 919	12, 474, 255			1, 498	50. 00
51. 00 05100 RECOVERY ROOM	0	(0.00000		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	(0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	493, 610	25, 004, 462			912	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0. 00000		0	55. 00
56. 00 05600 RADI OI SOTOPE	0	(0.00000		0	56. 00
57.00 05700 CT SCAN	0	(0.00000		0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0.00000	0 0	0	59. 00
60. 00 06000 LABORATORY	200, 695	19, 319, 440	0. 01038	40, 044	416	60.00
60. 01 06001 BLOOD LABORATORY	0	(0.00000	00	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0.00000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0.00000	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	(0. 00000	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	56, 489	5, 002, 269	0. 01129	49, 374	558	65. 00
66. 00 06600 PHYSI CAL THERAPY	7, 132	585, 016	0. 01219	2, 516	31	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0. 00000	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0		0. 00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	15, 672	2, 586, 624	0. 00605	10, 509	64	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0. 00000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	196, 727	15, 003, 863			0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	83, 621	7, 125, 381	0. 01173	3, 529	41	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	82, 943		1		401	73. 00
74.00 07400 RENAL DIALYSIS	0		0.00000		0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0		0.00000		0	75. 00
76. 98 07698 WOUND CARE	255, 891	4, 079, 041	1		0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	1	0.00000		0	77. 00
OUTPATIENT SERVICE COST CENTERS		•	•	•		
88. 00 08800 RURAL HEALTH CLINIC	0	(0.00000	00 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0. 00000	0 0	0	89. 00
90. 00 09000 CLI NI C	0		0. 00000	0 0	0	90.00
91. 00 09100 EMERGENCY	442, 849	21, 269, 234	0. 02082	24, 541	511	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0.00000		0	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	(0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0. 00000	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0.00000		0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		0.00000		0	98. 00
200.00 Total (lines 50 through 199)	2, 555, 548	117, 147, 978		225, 360	4, 432	200. 00
	•		•	•		

Health Financial Systems	MONROE H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III	pared:
		Ti †I	e XIX	Hospi tal	PPS	от рііі
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
oost conten bescription	Post-Stepdown	litar strig school	Post-Stepdowr		Medi cal	
	Adjustments		Adjustments	0031	Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	1 0	0	d .	0 0	0	30.00
				-		
31. 00 03100 INTENSIVE CARE UNIT	0			0		
32. 00 03200 CORONARY CARE UNIT	0		1	0		
33.00 03300 BURN INTENSIVE CARE UNIT	0	-		0		
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0)	0	0	
40. 00 04000 SUBPROVI DER - 1 PF	0	0)	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	41. 00
43. 00 04300 NURSERY	0	0)	0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
45.00 04500 NURSING FACILITY	0	l o)	0 0		45. 00
200.00 Total (lines 30 through 199)	0	l o)	0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	t Per Diem (col.	Inpatient	
, , , , , , , , , , , , , , , , , , ,	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•			'		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	3, 20	9 0.00	26	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 02	6 0.00	5	31.00
32.00 03200 CORONARY CARE UNIT		l o	i .	0.00	0	
33.00 03300 BURN INTENSIVE CARE UNIT		1 0	,	0.00	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	1	0.00	0	34.00
40. 00 04000 SUBPROVI DER - PF	0	0	1	0.00	Ō	
41. 00 04100 SUBPROVI DER - I RF	0			0.00	Ö	
43. 00 04300 NURSERY		١		0.00	l ő	
44. 00 04400 SKILLED NURSING FACILITY				0.00	Ö	
45. 00 04500 NURSING FACILITY				0.00	l	
200.00 Total (lines 30 through 199)						200.00
Cost Center Description	Inpati ent	0	4, 23	<u> </u>	J 1	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7,00					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNIT	0					31.00
32. 00 03200 CORONARY CARE UNIT	0	1				32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	1				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	Ö					34.00
40. 00 04000 SUBPROVI DER - 1 PF		1				40.00
41. 00 04100 SUBPROVI DER - 1 FF		1				41. 00
43. 00 04100 SUBPROVIDER - TRF 43. 00 04300 NURSERY		l .				43.00
44. 00 04400 SKILLED NURSING FACILITY	0	l .				44.00
45. 00 04500 NURSING FACILITY	0					45. 00
200.00 Total (lines 30 through 199)	0	1				200. 00

Peri od: Worksheet D
From 01/01/2018 Part IV
To 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm THROUGH COSTS

						5/26/2019 12:	54 piii
				e XIX	Hospi tal	PPS	
	Cost Center Description		Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATI NG ROOM	0	0	C	0	0	50.00
51. 00	05100 RECOVERY ROOM		l o			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM				0	0	52.00
53. 00	05300 ANESTHESI OLOGY				0	Ö	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
	i i				0	0	•
56. 00	05600 RADI OI SOTOPE	0			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	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	l c	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	l c	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	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS			1	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS				0	Ö	73. 00
74. 00	07400 RENAL DIALYSIS				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				·			
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS		<u></u>		0	0	77. 00
00 00	08800 RURAL HEALTH CLINIC		0		0		00.00
88. 00	I I	0	-		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	0	89. 00
90.00	09000 CLI NI C	0	0	1	0	0	90.00
91. 00	09100 EMERGENCY	0	C	1	_	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		C		0	92. 00
	OTHER REIMBURSABLE COST CENTERS	T	ı	T	T		
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
200.00	Total (lines 50 through 199)	0	0	C	0	0	200. 00

	H CUSTS				To 12/31/2018	Date/Time Pre 5/26/2019 12:	
			Ti tl	e XIX	Hospi tal	PPS	<u>от р</u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	T		T	T	Г	
	05000 OPERATI NG ROOM	0	0	(1
	05100 RECOVERY ROOM	0	0	(0	0.000000	1
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0. 000000	1
	05300 ANESTHESI OLOGY	0	0	(0	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0. 000000	1
	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0. 000000	•
	05600 RADI OI SOTOPE	0	0		0	0.000000	1
	05700 CT SCAN	0	0	(0	0. 000000	1
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(0	0. 000000	1
	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0. 000000	1
	06000 LABORATORY	0	0	(19, 319, 440	l	•
	06001 BLOOD LABORATORY	0	0	(0	0. 000000	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0. 000000	•
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0. 000000	•
	06400 I NTRAVENOUS THERAPY	0	0	(-	0. 000000	•
	06500 RESPI RATORY THERAPY	0	0	(5, 002, 269	0. 000000	ı
	06600 PHYSI CAL THERAPY	0	0	(585, 016	0. 000000	ı
	06700 OCCUPATI ONAL THERAPY	0	0	(0	0. 000000	1
	06800 SPEECH PATHOLOGY	0	0	(-	0. 000000	•
	06900 ELECTROCARDI OLOGY	0	0	(0. 000000	ł
	07000 ELECTROENCEPHALOGRAPHY	0	0	(1	0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0. 000000	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(7, 125, 381	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	0	0	(4, 698, 393	i e	•
	07400 RENAL DI ALYSI S	0	0	(0	0. 000000	1
	07500 ASC (NON-DISTINCT PART)	0	0	(-	0. 000000	1
	07698 WOUND CARE	0	0	(.,	0. 000000	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			1			
	08800 RURAL HEALTH CLINIC	0	0	(-	0.000000	1
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(-	0.000000	1
	09000 CLI NI C	0	0	(-	0.000000	1
	09100 EMERGENCY	0	0			0.000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(0	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS					0.00000	04.00
	09400 HOME PROGRAM DI ALYSI S	0	0	(0	0. 000000	94. 00
	09500 AMBULANCE SERVI CES	_	_		_		95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(<u>0</u>	0.000000	•
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(<u>0</u>	0.000000	•
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	(-	0.000000	•
200. 00	Total (lines 50 through 199)	0	0	(117, 147, 978	I	200. 00

Health Financial Systems	MONROE HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0183	
		E 04 (04 (0040 B 1 1))

From 01/01/2018 | Part IV To 12/31/2018 | Date/Time Prepared: THROUGH COSTS 5/26/2019 12:54 pm 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 25, 965 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 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 54.00 54.00 46, 174 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 40, 044 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 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 49, 374 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.000000 2, 516 0 66.00 06700 OCCUPATIONAL THERAPY 0. 000000 67 00 0 Ω 67 00 C 06800 SPEECH PATHOLOGY 68.00 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 10, 509 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 C 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71 00 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 3, 529 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 22, 708 0 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75 00 0.000000 75.00 Ω 0 76. 98 07698 WOUND CARE 0.000000 0 0 0 76.98 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 ol 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 89.00 0 0 90.00 90.00 09000 CLI NI C 0.000000 0 0 09100 EMERGENCY 0.000000 91.00 91.00 0 24, 541 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 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 0

225, 360

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems MONROE HAPPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Peri od: Worksheet D
From 01/01/2018
To 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm Provider CCN: 15-0183

						5/26/2019 12:	54 pm_
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
						(366 11131.)	
		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	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0. 370064	0	120, 321	0	0	50.00
		1	-		· ·		
51. 00	05100 RECOVERY ROOM	0. 000000			0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 116618	0	117, 388	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	Ö	56.00
					0		
57. 00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	0	0	59. 00
60.00	06000 LABORATORY	0. 117018	0	35, 194	0	Ō	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	1	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0	١	61.00
	1 1						
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0. 147139	0	l o	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 335847	l o		0	Ō	66. 00
		1	0		0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1	· -	U	_	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 165466	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 215774	l 0	l o	o	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 181960	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 291913	0	· -	0	Ö	73. 00
			1	· -	0	0	
74.00	07400 RENAL DIALYSIS	0. 000000	0		U		
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
76. 98	07698 WOUND CARE	0. 265795	0	38, 073	0	0	76. 98
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	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
			_				
90. 00	09000 CLI NI C	0. 000000	0	·	0	0	90. 00
91.00	09100 EMERGENCY	0. 179473	0	559, 241	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	•		•			1
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000		0			94. 00
95. 00	09500 AMBULANCE SERVICES	0. 000000	0				95.00
	1 1	1		· -			
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0	·	0	0	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0] 0	0	0	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	0	0	0	98. 00
200.00	Subtotal (see instructions)		0	870, 217	0	0	200. 00
201.00			_	1	٥		201. 00
201.00	Only Charges			I	l		[
202.00			0	870, 217	0	_	202. 00
202. UL	Inet charges (Time 200 - Time 201)	I	ı	0/0,21/	ı Y	ı	1202.00

					5/26/2019 12:54 pm
		_	Title XIX	Hospi tal	PPS
		Cost	ts		
	Cost Center Description	Cost	Cost		
	•	Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
			Ded. & Coins.		
		(see inst.)	(see inst.)		
		6.00	7.00		
ANC	LILADY CEDVICE COCT CENTERS	0.00	7.00		
	ILLARY SERVICE COST CENTERS	44 524			F0.00
	00 OPERATING ROOM	44, 526	0		50.00
	00 RECOVERY ROOM	0	0		51.00
	00 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53. 00 053	00 ANESTHESI OLOGY	0	0		53.00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	13, 690	0		54.00
55. 00 055	00 RADI OLOGY-THERAPEUTI C	o	o		55. 00
	00 RADI 0I SOTOPE	o	ol		56. 00
	00 CT SCAN		O		57.00
	OO MAGNETIC RESONANCE IMAGING (MRI)		Ö		58. 00
			0		
	OO CARDI AC CATHETERI ZATI ON				59.00
	00 LABORATORY	4, 118	0		60. 00
1	01 BLOOD LABORATORY	0	0		60. 01
61. 00 061	OO PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61.00
62.00 062	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62. 00
63. 00 063	OO BLOOD STORING, PROCESSING & TRANS.	0	O		63. 00
64. 00 064	OO INTRAVENOUS THERAPY	l ol	ol		64.00
	00 RESPIRATORY THERAPY	0	0		65. 00
	00 PHYSI CAL THERAPY	0	Ö		66.00
	00 OCCUPATI ONAL THERAPY		0		67. 00
	l e		- 1		
	00 SPEECH PATHOLOGY	0	0		68. 00
	00 ELECTROCARDI OLOGY	0	0		69. 00
	00 ELECTROENCEPHALOGRAPHY	0	0		70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72. 00 072	OO IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 073	OO DRUGS CHARGED TO PATIENTS	0	0		73. 00
74.00 074	00 RENAL DIALYSIS	o	o		74. 00
	00 ASC (NON-DISTINCT PART)	o	o		75. 00
	98 WOUND CARE	10, 120	O		76. 98
	OO ALLOGENEIC STEM CELL ACQUISITION	0	ol		77. 00
	PATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		77.00
			0		00.00
	OO RURAL HEALTH CLINIC	0	0		88. 00
	00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
	00 CLI NI C	0	0		90.00
91. 00 091	OO EMERGENCY	100, 369	0		91.00
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	О		92.00
ОТН	ER REIMBURSABLE COST CENTERS				
	00 HOME PROGRAM DIALYSIS	0	0		94. 00
	00 AMBULANCE SERVICES	o			95. 00
	OO DURABLE MEDI CAL EQUI P-RENTED	0	O		96. 00
	OO DURABLE MEDICAL EQUIP-RENTED		0		97.00
		1 1	- 1		
	50 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
200. 00	Subtotal (see instructions)	172, 823	0		200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0			201. 00
	Only Charges				1
202. 00	Net Charges (line 200 - line 201)	172, 823	0		202. 00

Health Financial Systems	MONROE HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/26/2019 12:54 pm
	Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/26/2019 12: PPS	54 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed room days (excluding swing-bed and observation bed day do not complete this line.	vate room days,	3, 209 3, 209 0	1. 00 2. 00 3. 00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		r 31 of the cost	3, 209 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	0 1		2, 279	9. 00
10. 00 11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	tions)	,	0	10.00
12. 00	Swing-bed SNr type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter O on this line)	, ,	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3	,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00					18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicald 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 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	4, 792, 866 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x,y)	31 of the cost reporting	period (line 8	0	25. 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, 792, 866	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line	, ,	tions)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	4, 792, 866	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		,		
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		Т		00.5-
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 493. 57	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		3, 403, 846 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		3, 403, 846	

Heal th	Financial Systems MONROE HOSPITAL In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0183 Period: From 01/01/2018	Worksheet D-1	
	To 12/31/2018		
	Title XVIII Hospital	PPS	54 piii
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Cost	
	col . 2)	4)	
42 00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 0 0 0.00 0	5.00	42. 00
	Intensive Care Type Inpatient Hospital Units		
43. 00 44. 00	INTENSIVE CARE UNIT		43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT 0 0.00		45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT 0 0.00 COUNTER SPECIAL CARE (SPECIFY)	0	46. 00 47. 00
47.00	Cost Center Description		47.00
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 4, 676, 683	48. 00
	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	8, 481, 592	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	541, 285	50. 00
30.00		541, 265	30.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	457, 827	51. 00
52. 00	Total Program excludable cost (sum of lines 50 and 51)	999, 112	•
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7, 482, 480	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54. 00 55. 00	Program di scharges Target amount per di scharge	0.00	
56. 00	Target amount (line 54 x line 55)	0.00	56. 00
57. 00		0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	58. 00 59. 00
	market basket		
60. 00 61. 00		0.00	60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
/ F 00	instructions)(title XVIII only)		4E 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XLX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
(0.00	(line 13 x line 20)		
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
7/ 00	26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limitation		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
84. 00	Program inpatient ancillary services (see instructions)		84. 00
85. 00 86. 00	Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)		85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87. 00 88. 00		0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instructions)		89. 00

Health Financial Systems	MONROE HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		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	673, 046	4, 792, 866	0. 14042	7 0	0	90.00
91.00 Nursing School cost	0	4, 792, 866	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 792, 866	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 792, 866	0. 00000	0 0	0	93. 00

Health Financial Systems	MONROE HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 5/26/2019 12:	
	Title XIX	Hospi tal	PPS	
Coot Conton Decement on				

The content of the			Title XIX	Hospi tal	5/26/2019 12: PPS	54 pm_
INSMITTER IMPS INSMITTER		Cost Center Description	TI LIE XIX	nospi tai	113	
IMPATIENT DAYS					1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 3,209 2.00						
5.00 Total swing-hed SRF type inpatient days (necluding private room days) after December 31 of the cost proporting period record and swing-hed SRF type inpatient days (including private room days) after December 31 of the cost proporting period record and period record and swing-hed SRF type inpatient days (including private room days) after December 31 of the cost proporting period of the cost period record and swing-hed NF type inpatient days (including private room days) after December 31 of the cost proporting period of the cost period record and swing-hed NF type inpatient days (including private room days) after December 31 of the cost proporting period (including private room days) after December 31 of the cost proporting period (including private room days) after December 31 of the cost proporting period (including private room days) after December 31 of the cost proporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost period period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after 32 of 32	2.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-Private room days (excluding swing-bed and observation bed days)	vate room days,	3, 209	2. 00	
Total swing-bed Nif type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this Line) 7.00		Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		31 of the cost		
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 line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Suling-bed SMbr syle Inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SMbr syle inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SMbr syle inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed SMb syle inpatient days applicable to titles V or XIX only (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16. 00 Indical inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 10 inverse days (if it is V or XIX only) 0 15. 00 10 inverse days (if it is V or XIX only) 0 15. 00 10 inverse days (if it is V or XIX only) 0 15. 00 10 inverse days (if it is V or XIX only) 0 15. 00 10 inverse days (if it is V or XIX only) 0 15. 00 10 inverse days (if it is V or XIX only) 0 15. 00 10 inverse days (if it is V or XIX only) 0 15. 00 10 inverse days (if it is V or XIX only) 0 1	6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in Calendar year, enter 0 on this line) 20	7. 00		n days) through December	31 of the cost	0	7. 00
newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title X Vor 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 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 16.00 Total nursery days (title V or XIX only) 16.00 Total nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost 10.00 Nedicared Inpatient NF NF NF NF NF NF NF NF NF NF NF NF NF	8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	I of the cost	0	8. 00
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16. 00 Nursery days (title V or XIX only) 16. 00 17. 00 18. 00		after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)		
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average perivate room per diem charge (line 29 + line 3) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential djustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 792, 866) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Swing-bed cost applicable to SNF type services through December		ng period (line		
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportino	g period (line 6	0	23. 00
x line 20) 26. 00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 Private room charges (excluding swing-bed and observation bed charges) 0 28. 00 Private room charges (excluding swing-bed charges) 0 29. 00 29. 00 Semi-private room charges (excluding swing-bed charges) 10. 00 20. 00 20. 00 20. 00 Average private room per diem charge (line 29 ÷ line 3) 20. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 20. 00 Average per diem private room cost differential (line 34 x line 31) 20. 00 Average per diem private room cost differential (line 34 x line 31) 20. 00 20. 00 20. 00 20. 00 Average per diem private room cost differential (line 34 x line 31) 20. 00 20. 00 20. 00 20. 00 Average per diem private room cost differential (line 34 x line 31) 20. 00 2	24. 00		31 of the cost reportin	ng period (line	0	24. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4,792,866 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 00 Private room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private 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 Average private room per diem charge (line 29 + line 3) 0. 00 33. 00 Average semi-private room per diem charge (line 30 + line 4) 0. 00 33. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0. 00 34. 00 34. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differential (line 3 x line 35) 0 36. 00 Average per diem private room cost differenti		x line 20)	31 of the cost reporting	period (line 8		
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 792, 866) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 792, 866) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 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 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, 792, 866) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 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	28. 00		and observation bed cha	arges)	0	28. 00
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) 34.00 Average per diem private room per diem charge (line 30 ÷ line 4) 35.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 36.00 Private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 792, 866) 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) 78.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.0000000000000000000000000000000000		Private room charges (excluding swing-bed charges)		3 ,		29. 00
32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 792, 866) 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) 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			line 20)		-	
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, 792, 866) 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		,	- II ne 28)			
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, 792, 866) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 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 34.00 37.00 35.00 4, 792, 866 37.00 38.00 38.00 38.833 39.00						
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 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) 36.00 37.0			nus line 33)(see instruct	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 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 A, 792, 866 37.00		, , ,	, ,	,		
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, 493.57 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,493.57 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	27 minus line 36)	and private room cost dit	ferential (line	4, 792, 866	37. 00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,493.57 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,493.57 38.00 40.00			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) 38,833 39.00 40.00	38 00				1 493 57	38, 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 38,833 41.00		, , , , , , , , , , , , , , , , , , , ,				
		, , , , , , , , , , , , , , , , , , , ,			38, 833	41. 00

Heal th	Financial Systems	MONROE HOS	SPI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CN: 15-0183	Peri od:	Worksheet D-1	
					From 01/01/2018 To 12/31/2018		
			Ti tl	e XIX	Hospi tal	5/26/2019 12: PPS	54 PIII
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0		00	0	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	2 0/7 701	1 02/	2.015	20 -	10.077	1 42 00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	2, 067, 791	1, 026 0	1			
45. 00	BURN INTENSIVE CARE UNIT		0	1			•
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	1		l e	•
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)			41, 204	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		90, 114	49. 00
F0 00	PASS THROUGH COST ADJUSTMENTS			. WI+ D	£ D-:-t- II	7.042	
50. 00	Pass through costs applicable to Program inpa	attent routine s	services (from	i wkst. D, Sur	n or Parts I and	7, 043	50. 00
51.00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	4, 432	51. 00
50.00	and IV)	50 L 54)					
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		ated non-phy	veician aneeth	natist and	11, 475 78, 639	1
33.00	medical education costs (line 49 minus line		ateu, non-pny	isi ci ali allesti	letist, and	70,037	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00						0	54. 00 55. 00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
57. 00	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	Ö	1
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	ending 1996, u	ipdated and co	ompounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	narket basket		0.00	60.00
61. 00						0	61. 00
	which operating costs (line 53) are less that						
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						
	Allowable Inpatient cost plus incentive payments	ent (see instruc	ctions)			0	63. 00
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +b	21 -6 +1-				
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through becen	iber 31 of the	e cost reporti	ng perrod (see	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	instructions)(title XVIII only)	no ocoto (lino ((4 plug lipo 4	E) (+: +1 o V)/III	l anly) Fan		44 00
66.00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (iine c	54 prus rine d	os)(title xvii	i oniy). For	0	66. 00
67. 00		e costs through	December 31 c	of the cost re	eporting period	0	67. 00
49.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs often Do	scombor 21 of	the cost rong	arting pariod		68. 00
00.00	(line 13 x line 20)	e costs after be	celliber 31 01	the cost repo	of tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU				<u> </u>	I	70.00
70.00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	,		,			72. 00
73.00	Medically necessary private room cost application						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74. 00 75. 00
73.00	26, line 45)	Toutine service	COSTS (TIOIII II	orksneet b, i	art II, Corumii		73.00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		rovi den irecond	ls)			78. 00 79. 00
80. 00	Total Program routine service costs for compa				nus line 79)		80. 00
81.00	'						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (:						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in:		-,				84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum		ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 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 01/01/2018	5	
				To 12/31/2018	Date/Time Prep 5/26/2019 12:	
		Ti tl	e XIX	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	673, 046	4, 792, 866	0. 14042	7 0	0	90.00
91.00 Nursing School cost	0	4, 792, 866	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 792, 866	0.00000	0	0	92. 00
93.00 All other Medical Education	o	4, 792, 866	0.00000	0 0	0	93. 00

Heal to Financial Systems Monroe Hospi			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Period: From 01/01/2018	Worksheet D-3	
		To 12/31/2018	Date/Time Pre	pared:
			5/26/2019 12:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description	Ratio of Cost		I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col . 1 x col .	
			2)	
INDATIONE CONTINUE CONTINUE CONTINUE CONTINUE	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 7/0 771		20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT		2, 768, 771 526, 501		30.00
		520, 501		31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT		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		40.00
41. 00 04100 SUBPROVI DER - FF		0		41. 00
43. 00 04300 NURSERY		0		43.00
ANCI LLARY SERVI CE COST CENTERS				45.00
50. 00 05000 0PERATING ROOM	0. 370064	3, 441, 755	1, 273, 670	50.00
51. 00 05100 RECOVERY ROOM	0. 000000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0.00000		Ö	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 116618		278, 037	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000		0	55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000		0	56. 00
57. 00 05700 CT SCAN	0. 000000		0	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000		0	59. 00
60. 00 06000 LABORATORY	0. 117018		322, 652	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000		0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		0	63.00
64. 00 06400 INTRAVENOUS THERAPY	0. 000000	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 147139	2, 862, 241	421, 147	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 335847	7 389, 115	130, 683	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 165466	701, 842	116, 131	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 215774	4, 048, 069	873, 468	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 181960	2, 734, 979	497, 657	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 291913	1, 946, 191	568, 118	73. 00
74. 00 07400 RENAL DI ALYSI S	0.000000	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75. 00
76. 98 07698 WOUND CARE	0. 265795		0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS		_		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000		0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000		0	89. 00
90. 00 09000 CLI NI C	0. 000000		0	90.00
91. 00 09100 EMERGENCY	0. 179473		195, 120	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		1		
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES				95. 00
96. 00 O9600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000		0	96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0.00000		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000		0	98. 00
Total (sum of lines 50 through 94 and 96 through 98)	(1)	22, 352, 827	4, 676, 683	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IINE 6I)	0		201. 00
202.00 Net charges (line 200 minus line 201)	I	22, 352, 827		202. 00

Health Financial Systems MONROE HOSP	ITAL	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0183	Peri od:	Worksheet D-3	
		From 01/01/2018		
		To 12/31/2018	Date/Time Pre	
			5/26/2019 12:	54 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Cos		Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	·	<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS		71, 463		30.00
31. 00 03100 NTENSI VE CARE UNI T		5, 274		31. 00
32. 00 03200 CORONARY CARE UNIT		3, 2, 4		32.00
ł				
i i		0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT		0		34.00
40. 00 04000 SUBPROVI DER - I PF		0		40. 00
41. 00 04100 SUBPROVI DER - I RF		0		41. 00
43. 00 <u>04300</u> NURSERY		0		43. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 3700	64 25, 965	9, 609	50.00
51. 00 05100 RECOVERY ROOM	0.0000	00 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.0000		0	52.00
53. 00 05300 ANESTHESI OLOGY	0.0000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1166		5, 385	54. 00
		· ·		
55. 00 O5500 RADI OLOGY-THERAPEUTI C	0.0000		0	55. 00
56. 00 05600 RADI 0I SOTOPE	0.0000		0	56. 00
57. 00 05700 CT SCAN	0.0000	00 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.0000	00	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.0000	00 0	0	59. 00
60. 00 06000 LABORATORY	0. 1170	18 40, 044	4, 686	60.00
60. 01 06001 BLOOD LABORATORY	0. 0000		0	60. 01
61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	0.0000		0	61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.0000		0	62. 00
ł				
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.0000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0.0000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 1471		7, 265	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 3358	47 2, 516	845	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0.0000	00	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.0000	00	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 1654	66 10, 509	1, 739	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.0000		0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 2157		0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 1819		642	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	•			
	0. 2919		6, 629	73.00
74. 00 07400 RENAL DI ALYSI S	0.0000		0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0.0000		0	75. 00
76. 98 07698 WOUND CARE	0. 2657	95 0	0	76. 98
77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION	0.0000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS				
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. 1794		4, 404	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0.0000	00	0	92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 O9400 HOME PROGRAM DIALYSIS	0.0000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.0000	00 0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.0000	00 0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0.0000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	5.0000	225, 360	41, 204	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	223, 300	71,204	201.00
	(TITIE OI)	225 240		
202.00 Net charges (line 200 minus line 201)	I	225, 360		202. 00

-		Title XVIII	Hospi tal	5/26/2019 12: 5 PPS	54 pm
		THE ATTEN	noop: tai		
	DART A LINDATION LOCALIAL CONVICES UNDER LONG			1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 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	ee	4, 275, 539	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring	on or after October 1	(see	1, 408, 268	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring p	rior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring o	n or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			57, 888	2. 00
2. 01 2. 02	Outlier reconciliation amount	1		0	2. 01 2. 02
3. 00	Outlier payment for discharges for Model 4 BPCI (see instructions Managed Care Simulated Payments)		0	3. 00
4. 00	Bed days available divided by number of days in the cost reportin Indirect Medical Education Adjustment	g period (see instruc	tions)	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	eriod ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the clow programs in accordance with 42 CFR 413.79(e)	riteria for an add-on	to the cap for	0. 00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified unde	r 42 CFR §412 105(f)(1) (i v) (B) (1)	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.			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	CA. 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 teachin	g hospi tal	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (s	ee	0. 00	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the current	vear from vour record	ls	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	year Trom your record			11. 00
12.00	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14. 00	Total allowable FTE count for the penultimate year if that year e	nded on or after Sept	ember 30, 1997,	0. 00	14. 00
15 00	otherwise enter zero.			0.00	15 00
15.00	Sum of lines 12 through 14 divided by 3.				15. 00 16. 00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital closure				17. 00
18. 00	Adjusted rolling average FTE count				18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20.00	Prior year resident to bed ratio (see instructions)			0. 000000	20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	21.00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident		D 412 10E	0.00	23. 00
23.00	(f) (1) (i v) (C).	cap stots under 42 cr	K 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 -O-, then enter the lowe	r of line 23 or line	24 (see		25. 00
	instructions)		•		
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
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 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
	Di sproporti onate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patie	nt days (see instruct	i ons)	3. 53	
31.00	Percentage of Medicaid patient days (see instructions)			9. 19	
32. 00 33. 00	Sum of lines 30 and 31			12. 72 0. 00	
	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)				34. 00
	1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		ı	٦١	

LCUL	Financial Systems MONROE HOS ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0183	Peri od: From 01/01/2018 To 12/31/2018		pared
		Title XVIII	Hospi tal	PPS	
				On/After 10/1	
	Uncompensated Care Adjustment		1. 00	2. 00	
. 00	Total uncompensated care amount (see instructions)		6 766 695 164	8, 272, 872, 447	35. (
. 01	Factor 3 (see instructions)		0. 000000000		
. 02	Hospital uncompensated care payment (If line 34 is zero, enteinstructions)	er zero on this line) (se	e 0	0	35. (
. 03	Pro rata share of the hospital uncompensated care payment amount of the uncompensated care (sum of columns 1 and 2 on line 35.0	03)	0	0	35. (36. (
. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		40. (
. 00	652, 682, 683, 684 and 685 (see instructions)	ui schai ges Tui M3-DRGS			40.
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, (instructions)	683, 684 an 685. (see	0		41. (
. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)		0		41. (
. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)		0.00		42. (43. (
. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. (
. 00	Average weekly cost for dialysis treatments (see instructions		447. 81		45.
. 00	Total additional payment (line 45 times line 44 times line 47 Subtotal (see instructions)	1.01)	5, 741, 695		46. 47.
. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	3, 741, 093		48.
	only. (see instructions)				
				Amount	
. 00	Total payment for inpatient operating costs (see instructions	2)		1. 00 5, 741, 695	49.
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			462, 464	50.
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	52.
. 00	Nursing and Allied Health Managed Care payment			0	53.
. 00	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 54.
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55.
. 00	Cost of physicians' services in a teaching hospital (see intr	· ·		0	56.
. 00	Routine service other pass through costs (from Wkst. D, Pt. I	III, column 9, lines 30 t	hrough 35).	0	57.
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58.
. 00	Total (sum of amounts on lines 49 through 58)			6, 204, 159	
. 00		- 1: (0)		0	60.
\sim	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	s rine 60)		6, 204, 159 673, 804	
. 00				25, 125	
. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			7, 252	
. 00				4, 714	
. 00 . 00 . 00				7, 252	1
. 00		tructions)		7,202	
. 00	Adjusted reimbursable bad debts (see instructions)	tructions)		5, 509, 944	67.
2. 00 3. 00 4. 00 5. 00 5. 00 7. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s		5, 509, 944 0	68.
2. 00 3. 00 3. 00 3. 00 3. 00 4. 00 3. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	applicable to MS-DRGs (s		5, 509, 944 0 0	68. 69.
2. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	applicable to MS-DRGs (s (For SCH see instruction	s)	5, 509, 944 0 0 0	68. 69. 70.
2. 00 3. 00 3. 00 3. 00 3. 00 4. 00 3. 00 0. 00 0. 50	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration)	applicable to MS-DRGs (s (For SCH see instruction	s)	5, 509, 944 0 0 0 0	68. 69. 70. 70.
2. 00 3. 00 3. 00 3. 00 3. 00 3. 00 4. 00 9. 00 9. 50 9. 87	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instabbtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration	applicable to MS-DRGs (s (For SCH see instruction	s)	5, 509, 944 0 0 0 0 0 0	68. 69. 70. 70. 70.
2. 00 3. 00 3. 00 3. 00 3. 00 4. 00 3. 00 0. 00 0. 50	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration)	applicable to MS-DRGs (s (For SCH see instruction tration) adjustment (see	s)	5, 509, 944 0 0 0 0	68. 69. 70. 70. 70. 70.
2. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 87 3. 88	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instabbtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	applicable to MS-DRGs (s (For SCH see instruction tration) adjustment (see	s)	5, 509, 944 0 0 0 0 0 0	68. 69. 70. 70. 70. 70. 70.
2. 00 3. 00 3. 00 3. 00 4. 00 4. 00 9. 00 9. 00 9. 87 9. 88 9. 89	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instable subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instable)	applicable to MS-DRGs (s (For SCH see instruction tration) adjustment (see	s)	5, 509, 944 0 0 0 0 0 0	68. 69. 70. 70. 70. 70. 70.
2. 00 3. 00 4. 00 5. 00 5. 00 6. 00 6. 00 6. 00 6. 50 6. 87 6. 88 6. 89 6. 90 6. 91 6. 92	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instable subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	applicable to MS-DRGs (s (For SCH see instruction tration) adjustment (see	s)	5, 509, 944 0 0 0 0 0 0 0	68. 69. 70. 70. 70. 70. 70. 70.
2. 00 3. 00 4. 00 5. 00 5. 00 6. 00 6. 00 6. 00 6. 00 6. 87 6. 88 6. 89 6. 90 6. 91	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instable subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs (s (For SCH see instruction tration) adjustment (see	s)	5, 509, 944 0 0 0 0 0 0 0	68. 69. 70. 70. 70. 70. 70. 70. 70.

			To 12/31/2018	Date/Time Pre 5/26/2019 12:	
	Title	xVIII	Hospi tal	PPS	<u>о т р</u>
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
the corresponding federal year for the period prior to 10/1)					
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
the corresponding federal year for the period ending on or af	ter 10/1)			_	
70. 98 Low Volume Payment-3				0	
70.99 HAC adjustment amount (see instructions)	(0 0 70)			15, 296	1
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 71.01 Sequestration adjustment (see instructions)	09 & 70)			5, 491, 274	1
71.01 Sequestration adjustment (see instructions) 71.02 Demonstration payment adjustment amount after sequestration				109, 825 0	
72.00 Interim payments				5, 477, 858	•
73.00 Tentative settlement (for contractor use only)				0,477,030	73. 00
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.0	2 72 and			-96, 409	•
73)	2, 72, 4.14			, , , , , ,	/ 00
75.00 Protested amounts (nonallowable cost report items) in accorda	nce with			341, 503	75. 00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90. 00
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00 Operating outlier reconciliation adjustment amount (see instr				0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
94.00 The rate used to calculate the time value of money (see instr	uctions)			0.00	•
95.00 Time value of money for operating expenses (see instructions)	+: 000)			0	
96.00 Time value of money for capital related expenses (see instruc	tions)		Prior to 10/1	0p/After 10/1	96. 00
			1.00	2. 00	
			1.00	2.00	
HSP Bonus Payment Amount					l
HSP Bonus Payment Amount 100.00 HSP bonus amount (see instructions)			0	0	100.00
100.00 HSP bonus amount (see instructions)			0	0	100. 00
			0. 0000000000	0. 0000000000	
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment	s)			0. 0000000000	
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions)	s)		0. 0000000000	0. 0000000000	101. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction)	s)		0. 0000000000	0. 0000000000	101. 00 102. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment			0.000000000	0. 0000000000 0	101. 00 102. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju		0.0000000000	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adju riod under t		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin) ration) Adju riod under t		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
100. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101. 00 HVBP adjustment factor (see instructions) 102. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103. 00 HRR adjustment factor (see instructions) 104. 00 HRR adjustment factor (see instructions) 104. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 202. 00 Medicare discharges (see instructions)) ration) Adju riod under t		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
100. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 101. 00 HVBP adjustment factor (see instructions) 102. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103. 00 HRR adjustment factor (see instructions) 104. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 200. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 202. 00 Medicare discharges (see instructions) 203. 00 Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	the 21st	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
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Provider CCN: 15-0183

1.00 BBG amounts other than outli or 1.00 1.00 1.00 2.00 3.00 0.4.00 1.00					Ti +I o	VV/LLL	Hospi tal	5/26/2019 12:	54 pm
1.00 DRG amounts other than outlier 1.00 0 1.00 2.00 3.00 0 4.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 0 0 0 0 0 0 0 0			W/S F Dart A	Amounts (from			Hospi tal	PPS Total (Col. 2	
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Coccurring prior to Götober 1, 408, 268	1. 01	DRG amounts other than outlier	1. 01	4, 275, 539	0	4, 275, 539		4, 275, 539	1. 01
payments for discharges									
Operating payment for Note 4 8PCI Occurring prior to Cotober 1 1.04 0 0 0 0 0 0 0 0 0	1. 02	payments for discharges	1. 02	1, 408, 268	0		1, 408, 268	1, 408, 268	1. 02
1,04 DRC for Federal specific 1,04 0 0 0 0 0 0 0 0 0	1. 03	operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
2.00 Outlier payments for 2.00 57,888 0 49,276 8,612 57,888 2 discharges (see instructions) 0.00 0 0 0 0 0 0 0 0	1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2.01 Outlier payments for 2.02 0 0 0 0 0 0 2 2 2	2. 00	Outlier payments for	2. 00	57, 888	0	49, 276	8, 612	57, 888	2. 00
3.00 Operating outlier 2.01 O O O O O O O O O	2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
Managed care simulated 3.00 0 0 0 0 0 0 0 0 0	3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
Indirect Modical Education Adjustment	4.00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
5.00 Amount from Worksheet E, Part 21:00 0.00000 0.000000 0.00000000			ustment	<u> </u>					1
0.00 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5.00			0. 000000	0. 000000	0. 000000	0. 000000		5.00
Second S	6. 00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
Instructions	6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
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See instructions Section Secti	7.00						0.000000		7 00
Instructions Robot Impairment adjustment add on 28.01 0 0 0 0 0 0 0 0 0		(see instructions)		0.000000	0.000000	0.000000	0.000000		7. 00
For managed care (see instructions)		instructions)		0	0	0	0	0	8. 00
9.01 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 All lowable disproportionate share Adjustment 33.00 0.00000 0.000000	8. 01	for managed care (see	28. 01	0	0	0	0	0	8. 01
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share adjustment 11.00 Disproportionate share adjustment 11.00 Disproportionate share adjustment 11.00 Disproportionate share adjustment 11.00 Disproportionate share adjustment (see instructions) 11.01 Disproportionate share adjustment (see instructions) 11.02 Disproportionate share adjustment (see instructions) 11.03 Disproportionate share adjustment (see instructions) 11.04 Disproportionate share adjustment (see instructions) 12.05 Total ESRD additional payment decrease of ESRD beneficiary discharges 12.06 Total ESRD additional payment decrease decrease additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments decrease decre	9. 00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
Disproportionate Share Adjustment 10.00	9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
10.00			ent						
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11.00 Disproportionate share adjustment (see instructions) 11.01 Uncompensated care payments Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 18.00 Total representation of the program of t									
11.01 Uncompensated care payments 36.00 0 0 0 0 0 0 0 0 0	11. 00	Di sproporti onate share	34.00	0	0	0	0	0	11. 00
12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 12 13.00 Subtotal (see instructions) 47.00 5,741,695 0 4,324,815 1,416,880 5,741,695 13 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from 68.00 0 0 0 0 0 0 0 0 0	11. 01	Uncompensated care payments		0		0	0	0	11. 01
(see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technol ogies 18.00 O O O O O O O O O O O O O O O O O O				RD beneficiary					
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16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from 50.00 462, 464 0 346, 345 116, 119 462, 464 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49. 00	5, 741, 695	0	4, 324, 815	1, 416, 880	5, 741, 695	15. 00
17. 00 Special add-on payments for new technologies 54.00 0 0 0 0 0 17.01 0 <td>16. 00</td> <td>Payment for inpatient program capital (from Wkst. L, Pt. I,</td> <td>50. 00</td> <td>462, 464</td> <td>0</td> <td>346, 345</td> <td>116, 119</td> <td>462, 464</td> <td>16. 00</td>	16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	462, 464	0	346, 345	116, 119	462, 464	16. 00
17. 01 Net organ aquisition cost 17. 02 17. 02 Credits received from 68. 00 0 0 0 0 0	17. 00	Special add-on payments for	54. 00	0	0	0	0	0	17. 00
devices for applicable MS-DRGs		Net organ aquisition cost Credits received from manufacturers for replaced		0	0	0	0	0	17. 01 17. 02

Health Financial Systems	MONROE HOSPITAL	In Lie	u of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provi der CCN: 15-0183		Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2019 12:54 pm

						o 12/31/2018	Date/Time Pre 5/26/2019 12:	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	C	0	0	
19. 00	SUBTOTAL			0	4, 671, 160	1, 532, 999	6, 204, 159	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	458, 101	0	343, 968	114, 133	458, 101	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	C	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	4, 363	0	2, 377	1, 986	4, 363	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	C	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	462, 464	0	346, 345	116, 119	462, 464	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 177321	0.000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			828, 295		828, 295	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

 Heal th Financial
 Systems
 MONROE
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 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT
 5
 Provider CCN: 15-0183

				10	0 12/31/2018	5/26/2019 12:	
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Peri od on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00					1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	4, 275, 539	4, 275, 539		4, 275, 539	1. 01
	discharges occurring prior to October 1	4.00	4 400 040		4 400 040	4 400 040	4 00
1. 02	DRG amounts other than outlier payments for	1. 02	1, 408, 268		1, 408, 268	1, 408, 268	1. 02
1 02	discharges occurring on or after October 1	1 02	0	0		0	1 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		U	1. 03
	1						
1.04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2.00	57, 888	49, 276	8, 612	57, 888	2.00
	instructions)						
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2 00	BPCI	2 01			0		2 00
3. 00 4. 00	Operating outlier reconciliation	2. 01 3. 00	0	0	0	0	3. 00 4. 00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	U	U	U	U	4.00
5. 00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
5.00	(see instructions)	21.00	0.00000	0.000000	0.00000		3.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)		_	_	_	_	
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	U	U	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	o	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0	0	0	0	9. 01
7. 01	lines 6.01 and 8.01)	27.01			0	O	7. 01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0.0000	0.0000	0.0000		10. 00
	(see instructions)						
11. 00	Di sproporti onate share adjustment (see	34.00	0	0	0	0	11. 00
	instructions)	0, 00					
11. 01	Uncompensated care payments	36.00	0	0	0	0	11. 01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see	46. 00	or scriai ges	0	0	0	12. 00
12.00	instructions)	40.00			0	0	12.00
13.00	Subtotal (see instructions)	47. 00	5, 741, 695	4, 324, 815	1, 416, 880	5, 741, 695	13. 00
14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	5, 741, 695	4, 324, 815	1, 416, 880	5, 741, 695	15. 00
47.00	(see instructions)	F0 00	4/0 4/4	044 045	444 440	4/0 4/4	47.00
16. 00	Payment for inpatient program capital (from	50. 00	462, 464	346, 345	116, 119	462, 464	16. 00
17. 00	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54.00	0	0	0	o	17. 00
17. 00	Net organ acquisition cost	54.00	J	U	U	0	17. 00
17. 01	Credits received from manufacturers for	68. 00	n	n	n	0	
17.02	replaced devices for applicable MS-DRGs	55. 55]	9	Ĭ	. , . 02
18. 00	Capital outlier reconciliation adjustment	93.00	0	0	0	0	18. 00
	amount (see instructions)						
19. 00	SUBTOTAL			4, 671, 160	1, 532, 999	6, 204, 159	19. 00

		WKSt. L, IIIIe	(Allit. ITOIII				
			Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	458, 101	343, 968	114, 133	458, 101	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	4, 363	2, 377	1, 986	4, 363	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0. 0000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	462, 464	346, 345	116, 119	462, 464	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-839	0	-839	-839	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-2, 535	0	-2, 535	-2, 535	31. 00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
	HAC Reduction Program adjustment (see instructions)	70. 99		0	15, 296	15, 296	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	MONROE HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0183	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/26/2019 12:54 pm

		5/26/2019 12:	54 pm
	Title XVIII Hospital	PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	119	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4, 061, 026	
3.00	OPPS payments	2, 237, 020	
4.00	Outlier payment (see instructions)	30, 528	4. 00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5. 00
6.00	Line 2 times line 5	0.00	6. 00 7. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9. 00
10.00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	119	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges	T	
	Ancillary service charges		12.00
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	553	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges	333	14.00
15. 00		0	15. 00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	
18.00	Total customary charges (see instructions)	553	•
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	434	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
20.00	instructions)		20.00
21. 00	Lesser of cost or charges (see instructions)	119	21. 00
22. 00		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	2, 267, 548	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	111	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	454, 116	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 813, 440	
	instructions)		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	1 013 440	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments	1, 813, 440	30. 00 31. 00
32. 00		1, 813, 440	
	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	· · · · · · · · · · · · · · · · · · ·	3, 973	•
35. 00	, ,	2, 582	
36. 00 37. 00	· · · · · · · · · · · · · · · · · · ·	3, 973	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	1, 816, 022	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		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, 816, 022	•
40. 01	Sequestration adjustment (see instructions)	36, 320	40. 01 40. 02
40. 02 41. 00	Demonstration payment adjustment amount after sequestration Interim payments	1, 777, 209	
42. 00	Tentative settlement (for contractors use only)	1,777,207	42. 00
43. 00	Balance due provider/program (see instructions)	2, 493	
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2		
00.00	TO BE COMPLETED BY CONTRACTOR		00.00
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0	90. 00 91. 00
91.00	· · · · · · · · · · · · · · · · · · ·	1	91.00
	Time Value of Money (see instructions)	0.00	1
	Total (sum of lines 91 and 93)		94. 00

Peri od: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/26/2019 12:54 pm Provider CCN: 15-0183

Inpatient Part A						5/26/2019 12: 5	54 pm
Total interim payments paid to provider 1.00 2.00 3.00 4.00 4.00					Hospi tal	PPS	
1.00 2.00 3.00 4.00 1.00 1.00 2.00 3.00 4.00 1.00			·				
1.00							
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero.	4 00		1. 00				
Submitted or to be Submitted to the contractor For services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 1st separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 3.01 3.02 3.03 0 0 0 3.02 3.03 3.04 3.06 3.08 3.09 3.08 3.08 3.09 3.09 3.09 3.09 3.09 3.00							
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero test separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	2.00			(ار	ا	2.00
write "NONE" or enter a Zero 3. 00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 ADJUSTMENTS TO PROVIDER 3. 00 0 0 3. 03 3. 03 0 0 0 3. 03 3. 03 0 0 0 0 3. 03 3. 04 0 0 0 0 3. 03 3. 05 0 0 0 0 3. 03 3. 05 0 0 0 0 3. 05 3. 50 0 0 0 0 3. 05 3. 51 0 0 0 0 3. 55 3. 52 0 0 0 0 3. 55 3. 53 0 0 0 0 3. 55 3. 53 0 0 0 0 3. 55 3. 54 0 0 0 0 3. 55 3. 54 0 0 0 0 3. 55 3. 54 0 0 0 0 3. 55 3. 54 0 0 0 0 3. 55 3. 55 0 0 0 0 3. 55 3. 56 0 0 0 0 3. 55 3. 57 0 0 0 0 3. 55 3. 58 0 0 0 0 3. 55 3. 59 8) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR TO BE							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
Bayment. If none, write "NONE" or enter a zero. (1)		amount based on subsequent revision of the interim rate					
Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3.01							
3.01 ADJUSTMENTS TO PROVIDER							
3. 02 0	0.04				-l		0.04
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR TENTATIVE TO PROVIDER 5.00 Provider to Program TENTATIVE TO PROVIDER TENTATIVE TO PROVIDER TENTATIVE TO PROVIDER TENTATIVE TO PROGRAM TENT		ADJUSTMENTS TO PROVIDER					
3.04							
3.05							
Provider to Program							
3. 50 ADJUSTMENTS TO PROGRAM	0.00	Provider to Program		<u> </u>	21	ı	0.00
3.52 3.53 3.54 3.99 3.50-3.98	3.50			(o l	0	3.50
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.50-3,98 3.50-3,98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 0 5.01 5.02 0 0 0 5.03 0 0 0 5.03 0 0 0 5.52 0 0 0 0 5.55 0 0 0 0 0 0 5.55 0 0 0 0 0 0 0 0 0	3.51			(D	0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 5,477,858 1,777,209 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR						- 1	3. 52
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 3. 99 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 5, 477, 858 1, 777, 209 4. 00 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 5, 477, 858 1, 777, 209 4. 00 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 5, 477, 858 1, 777, 209 4. 00 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 5, 477, 858 1, 777, 209 4. 00 Total Medicare program to Wiston Endowment of the sum of lines 2, 200 5, 477, 858 1, 777, 209 4. 00 4. 0							3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99)						- 1	3. 54
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-0r Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99			(O	0	3. 99
Contractor Con	4 00			E 477 OE		1 777 200	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			3, 477, 636		1, 111, 209	4.00
TO BE COMPLETED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider O							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					<u>'</u>		
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5.00
Program to Provider TENTATIVE TO PROVIDER							
TENTATI VE TO PROVIDER							
5.02 0	E 04				-l		F 04
S. 03 Provider to Program S. 50 TENTATIVE TO PROGRAM O O S. 50		TENTATIVE TO PROVIDER					
Provider to Program							
S. 50 TENTATIVE TO PROGRAM 0 0 5. 50	5.05	Provider to Program		<u>'</u>	<u> </u>	0	5. 05
5.51 5.52 5.52 5.53 5.55	5. 50			(0	5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 2,493 6.01 6.02 SETTLEMENT TO PROGRAM 96,409 0 6.02 7.00 Total Medicare program liability (see instructions) 5,381,449 1,779,702 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 51			(o	0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.52			(O	0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99			(O	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00		1 2 2 2 2 2 2					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 96, 409 5, 381, 449 1, 779, 702 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01					2 402	6 01
7.00 Total Medicare program liability (see instructions)					٥,	2, 493	
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						1 779 702	7. 00
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	inca. ca. c program rrabitity (see thistractions)		0, 001, 44			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems MONROE HOS	PI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0183	Peri od:	Worksheet E-	1
			From 01/01/2018 To 12/31/2018		epared:
				5/26/2019 12:	
		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.		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	63			
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
22 00	Polones due provider (line 0 (en line 10) minus line 20 and l	ing 21) (and instruction)		22.00

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 MON	IROE HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0183	Peri od: From 01/01/2018	Worksheet E-3 Part VII Date/Time Prepared:

			0 12/31/2018	Date/lime Pre 5/26/2019 12:	
		Title XIX	Hospi tal	PPS	<u>о г р</u>
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			172, 823	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	172, 823	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	172, 823	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		76, 737		8. 00
9. 00	Ancillary service charges		225, 360	870, 217	9. 00
10. 00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		302, 097	870, 217	12.00
40.00	CUSTOMARY CHARGES		1		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14.00	basis			0	14 00
14. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		0	0	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0.000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		302, 097	870, 217	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	302, 097	697, 394	
17.00	line 4) (see instructions)	y 11 1111c 10 exceeds	302,077	077, 374	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y		Ü	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	16)	0	172, 823	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	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
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	172, 823	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	172, 823	
32.00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review	4 22)	0	170 000	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	0	172, 823	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		0	172 022	37. 00 38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	172, 823	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	172, 823	
41. 00	Interim payments		0	172, 823	41.00
41.00	Balance due provider/program (line 40 minus line 41)		0	172, 823	
43. 00	Protested amounts (nonallowable cost report items) in accordan	ace with CMS Dub 15_2	0	172, 623	42.00
73.00	chapter 1, §115.2	IOC WI EII OWO I UD 13-2,			75.00
	1h		1		'

	Financial Systems MONROE H	OSPI TAL			u of Form CMS-	2552-10
	E SHEET (If you are nonproprietary and do not maintain	Provi der Co		Period: From 01/01/2018	Worksheet G	
fund-t only)	ype accounting records, complete the General Fund column			To 12/31/2018	Date/Time Pre	pared:
——————————————————————————————————————	,				5/26/2019 12:	
		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	1, 695, 936	1	0	0	1.00
2.00	Temporary investments	0		0 0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	33, 851, 332		0 0	0	3. 00 4. 00
5. 00	Other recei vable	7, 006, 815			0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-26, 476, 235		o o	0	6. 00
7.00	Inventory	722, 368		0 0	0	7. 00
8.00	Prepai d expenses	636, 929	1	0	0	8. 00
9.00	Other current assets	0		0	0	1
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	17, 437, 145		0 0	0	10.00
11.00	FIXED ASSETS	17, 437, 143	<u> </u>	0	0	11.00
12. 00	Land	1, 300, 000		0 0	0	12. 00
13. 00	Land improvements	0		0 0	0	13. 00
14. 00	Accumulated depreciation	0		0 0	0	14. 00
15. 00	Bui I di ngs	8, 000, 000	•	0	0	15. 00
16.00	Accumulated depreciation	-2, 133, 332		0 0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	557, 607 -136, 769		0 0	0	17. 00 18. 00
19. 00	Fi xed equi pment	9, 407, 075			0	19.00
20. 00	Accumulated depreciation	-3, 891, 508		ol ol	0	20.00
21. 00	Automobiles and trucks	0	1	o o	0	21. 00
22. 00	Accumulated depreciation	0		o o	0	22. 00
23. 00	Major movable equipment	930, 278	•	0	0	23. 00
24. 00	Accumulated depreciation	-678, 182	1	0	0	24. 00
25. 00 26. 00	Minor equipment depreciable	0		0 0	0	25. 00 26. 00
27. 00	Accumulated depreciation HIT designated Assets	0		0 0	0	27.00
28. 00	Accumulated depreciation	0			0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		o o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	13, 355, 169		0 0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	0		0 0	0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers	0		0 0	0	32. 00 33. 00
34. 00	Other assets	357, 872			0	34.00
35. 00	Total other assets (sum of lines 31-34)	357, 872		o o	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	31, 150, 186		0 0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	1, 169, 491	•	0	0	37. 00
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	1, 270, 095	1	0 0	0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)	134, 381 1, 539, 812	•	0 0	0	
41. 00	Deferred income	154, 251			0	1
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	27, 189, 355		o o	0	43. 00
44. 00	Other current liabilities	747, 061		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	32, 204, 446	1	0 0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	5, 000, 000		ol o	0	46. 00
47. 00	Notes payable	610, 252	•		0	47. 00
48. 00	Unsecured Loans	0	1	o o	0	
49.00	Other long term liabilities	10, 842, 783		0 0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16, 453, 035		0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	48, 657, 481		0 0	0	51.00
E2 00	CAPITAL ACCOUNTS	17 507 205	I			52.00
52. 00 53. 00	General fund balance Specific purpose fund	-17, 507, 295		o		52.00
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				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-17, 507, 295			0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	31, 150, 186	•	o ol	0	
	[59]					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES MONROE HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0183

					10 12/31/2018	5/26/2019 12:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
					Г		
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	-12, 648, 691		4.00		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		-3, 827, 168		`	1	2.00
3.00	Total (sum of line 1 and line 2)		-16, 475, 859				3. 00
4.00	CREDIT ADJUSTMENTS	-1, 031, 436	.,,		0	0	4. 00
5.00		0			0	0	5. 00
6.00		o			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		-1, 031, 436		(10.00
11. 00	Subtotal (line 3 plus line 10)		-17, 507, 295		(11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13. 00		0			0	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0	_		0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		0		(18.00
19. 00	Fund balance at end of period per balance		-17, 507, 295		()	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Ziidoiiiioiit i diid		1 4.14			
		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	CREDIT ADJUSTMENTS		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00	T		Ü				9.00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	U	0		U		11. 00 12. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)		0				12.00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)		U		0		18.00
19. 00	Fund balance at end of period per balance				0		19.00
17.00	sheet (line 11 minus line 18)						17.00
	12	1		'	1		1

Provider CCN: 15-0183

			10 12/31/2018	5/26/2019 12:	
	Cost Center Description	Inpati ent	Outpati ent	Total	5 T 5111
	' 	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	5, 760, 43	5	5, 760, 435	1.00
2.00	SUBPROVI DER - I PF)	0	2.00
3.00	SUBPROVI DER - I RF)	0	3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF)	0	5. 00
6.00	Swing bed - NF)	0	6. 00
7.00	SKILLED NURSING FACILITY)	0	7. 00
8.00	NURSING FACILITY	•	O	0	8. 00
9.00	OTHER LONG TERM CARE		O	0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 760, 43	5	5, 760, 435	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	2, 568, 100	I I	2, 568, 100	11. 00
12. 00	CORONARY CARE UNIT)	0	12. 00
13. 00	BURN INTENSIVE CARE UNIT	1	D	0	13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT	(0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	2, 568, 100)	2, 568, 100	16. 00
47.00	11-15)	0.000.50	_	0 000 505	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 328, 53		8, 328, 535	17. 00
18. 00	Ancillary services	32, 145, 55		117, 147, 979	18. 00
19. 00	Outpati ent servi ces		0	0	19. 00
20.00	RURAL HEALTH CLINIC	•		0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	1	0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES	1	0	0	23. 00
24. 00	CMHC		0	0	24. 00
24. 10	CORF			0	24. 10
24. 11	CORF			0	24. 11
25. 00 26. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE			0	25. 00 26. 00
				-	
27. 00 28. 00	OTHER (SPECIFY)		- 1	125 477 514	27. 00 28. 00
26.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40, 474, 08	85, 002, 426	125, 476, 514	26.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		33, 322, 887		29. 00
30. 00	ADD (SPECIFY)	1	0 33, 322, 667		30. 00
31. 00	(SI ECIT I)				31. 00
32. 00		I			32. 00
33. 00					33. 00
34. 00					34. 00
35. 00		1			35. 00
36. 00	Total additions (sum of lines 30-35)		o		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00			o I		38. 00
39. 00			ol l		39. 00
40. 00		1	ol l		40. 00
41. 00			ol l		41. 00
42. 00	Total deductions (sum of lines 37-41)		o		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	33, 322, 887		43. 00
	to Wkst. G-3, line 4)		,		
		•			

	Financial Systems	MONROE HOSPITAL		in Lie	u of Form CMS-2	
TATEN	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15		/01 /0010	Worksheet G-3	
				/01/2018 2/31/2018	Date/Time Pre	pare
			1.5		5/26/2019 12:	
	T + 1	1 0 11 00)			1.00	-
. 00	Total patient revenues (from Wkst. G-2, Part I,				125, 476, 514	
. 00	Less contractual allowances and discounts on pat	Tents accounts			96, 131, 495	
. 00	Net patient revenues (line 1 minus line 2)				29, 345, 019	
. 00	Less total operating expenses (from Wkst. G-2, P				33, 322, 887	
00	Net income from service to patients (line 3 minus OTHER INCOME	s line 4)			-3, 977, 868	5.
00	Contributions, donations, bequests, etc				0	6.
00	Income from investments				236	
00	Revenues from telephone and other miscellaneous	communication services			0	
00	Revenue from television and radio service	30. V. 30.			0	
. 00	Purchase di scounts				0	
	Rebates and refunds of expenses				0	
	Parking lot receipts				0	
	Revenue from Laundry and Linen service				0	1
	Revenue from meals sold to employees and guests				112, 444	
	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical suppli	es to other than patients			0	
	Revenue from sale of drugs to other than patients				0	
	Revenue from sale of medical records and abstrac				187	
	Tuition (fees, sale of textbooks, uniforms, etc.				0	
. 00	Revenue from gifts, flowers, coffee shops, and compared to the shops and compared to the shops and compared to the shops are the shops and compared to the shops are the s				0	
. 00	Rental of vending machines	a			0	
. 00	Rental of hospital space				0	
. 00	Governmental appropriations				0	
. 00	LAB				96	
	DI ETARY				37, 737	
	Total other income (sum of lines 6-24)				150, 700	
	Total (line 5 plus line 25)				-3, 827, 168	
	OTHER EXPENSES (SPECIFY)				-3, 027, 100	
	Total other expenses (sum of line 27 and subscri	nts)			0	
	Net income (or loss) for the period (line 26 min				-3, 827, 168	

ALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0183	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	5/26/2019 12: PPS	54 p
			110001 101	10	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
00	Capital DRG other than outlier			458, 101	
01	Model 4 BPCI Capital DRG other than outlier			0	1 .
00	Capital DRG outlier payments			4, 363	
01	Model 4 BPCI Capital DRG outlier payments			0	
00	Total inpatient days divided by number of days in the cost r	eporting period (see inst	tructions)	11. 60	
00	Number of interns & residents (see instructions)			0.00	
00	Indirect medical education percentage (see instructions)	611 4 14 06		0. 00	
00	Indirect medical education adjustment (multiply line 5 by th 1.01)(see instructions)			0	
00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	E, part A line	0. 00	7
00	Percentage of Medicaid patient days to total days (see instr	uctions)		0.00	8
00	Sum of lines 7 and 8			0.00	9
. 00	Allowable disproportionate share percentage (see instruction	s)		0.00	10
	Disproportionate share adjustment (see instructions)			0	11
. 00	Total prospective capital payments (see instructions)			462, 464	12
				1 00	
	DADT LL DAVMENT LINDED DEACONABLE COCT			1. 00	
00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (see Instructions)			0	
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	
50	Total impatient program capital cost (Time 3 x Time 4)			0	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
00	Program inpatient capital costs (see instructions)			0	1
00	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			0	1
00	Applicable exception percentage (see instructions)			0.00	4
00	Capital cost for comparison to payments (line 3 x line 4)			0	
00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	1
00	Adjustment to capital minimum payment level for extraordinar	y circumstances (line 2)	(line 6)	0	7
00	Capital minimum payment level (line 5 plus line 7)			0	1 -
00	Current year capital payments (from Part I, line 12, as appl			0	9
. 00	Current year comparison of capital minimum payment level to		,	0	
. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11
00	Net comparison of capital minimum payment level to capital p	ayments (line 10 plus lir	ne 11)	0	12
. 00	Current year exception payment (if line 12 is positive, ente			0	13
	Carryover of accumulated capital minimum payment level over			0	14
. 00	(II TINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS TIME)				
	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see in	structions)		0	15
. 00 . 00 . 00		structi ons)		0	1