

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 4/13/2016 9:18 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 4/13/2016 Time: 9:18 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 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 WOODLAWN HOSPITAL ( 151313 ) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-119,629	24,444	0	13,451	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-10,110	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	-129,739	24,444	0	13,451	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 151313		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 4/13/2016 9:17 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1400 EAST 9TH STREET			PO Box:							
2.00	City: ROCHESTER			State: IN		Zip Code: 46975-		County: FULTON			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		WOODLAWN HOSPITAL	151313	99915	1	01/01/1966	N	0	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		WOODLAWN HOSPITAL SWINGBED	152313	99915		10/23/2001	N	0	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										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
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2015	12/31/2015		20.00	
21.00	Type of Control (see instructions)						8		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for 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 §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this 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)						N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care 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.						N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to 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 reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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.			0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0	25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 4/13/2016 9:17 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N		N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00	2.00	3.00
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110.00
					1.00	
					2.00	
					3.00	
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	90,202	23,617		0	118.01
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 4/13/2016 9:17 am			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00		
				1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for 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.	N			145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? 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.	N			146.00		
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N	147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	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	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	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 reasonable cost incurred for the HIT assets (see instructions)				168.00		
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 transition factor. (see instructions)			0.00	169.00		
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			01/01/2015	12/31/2015	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 4/13/2016 9:17 am
			1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 4/13/2016 9:17 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/04/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 4/13/2016 9:17 am
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	Description	Part A		Part B		
		Y/N	Date	Y/N		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	2.00	3.00	21.00
		N			N	
					1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
			Y/N	Date		
			1.00	2.00		
<b>Home Office Costs</b>						
36.00	Were home office costs claimed on the cost report?				N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
<b>Cost Report Preparer Contact Information</b>						
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.	KYLE			SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957			KCSMI TH@BLUEANDCO. COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-2  
Part II  
Date/Time Prepared:  
4/13/2016 9:17 am

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/04/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
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.	SENIOR MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	92,136.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	92,136.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	12,912.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	105,048.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance 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)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,279	113	3,839			1.00
2.00 HMO and other (see instructions)	607	385				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	99	0	99			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	48			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,378	113	3,986			7.00
8.00 INTENSIVE CARE UNIT	242	0	538			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		0	0			13.00
14.00 Total (see instructions)	1,620	113	4,524	0.00	407.25	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	407.25	27.00
28.00 Observation Bed Days		0	899			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	394	40	1,080	1.00
2.00	HMO and other (see instructions)			171	178		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation 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	394	40	1,080	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance 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 outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 4/13/2016 9:17 am
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.330436		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,427,296		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,157,291		5.00
6.00	Medicaid charges		8,060,258		6.00
7.00	Medicaid cost (line 1 times line 6)		2,663,399		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		78,812		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		78,812		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,862,464	0	1,862,464	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	615,425	0	615,425	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	615,425	0	615,425	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,274,220		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		342,717		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,931,503		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,299,110		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,914,535		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,993,347		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		2,391,262	2,391,262	-107,575	2,283,687	1.00
1.02	00102		47,608	47,608	0	47,608	1.02
1.03	00103		84,274	84,274	0	84,274	1.03
1.04	00101		12,569	12,569	107,575	120,144	1.04
4.00	00400	182,480	3,992,595	4,175,075	0	4,175,075	4.00
5.00	00500	2,537,299	2,420,689	4,957,988	92,184	5,050,172	5.00
7.00	00700	328,222	1,214,852	1,543,074	0	1,543,074	7.00
8.00	00800	10,729	101,639	112,368	0	112,368	8.00
9.00	00900	314,611	145,711	460,322	0	460,322	9.00
10.00	01000	366,878	309,789	676,667	-430,099	246,568	10.00
11.00	01100	0	0	0	430,099	430,099	11.00
13.00	01300	156,808	44,554	201,362	0	201,362	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	289,498	3,112,693	3,402,191	0	3,402,191	15.00
16.00	01600	611,092	242,914	854,006	0	854,006	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,097,586	699,236	2,796,822	0	2,796,822	30.00
31.00	03100	444,919	159,410	604,329	0	604,329	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	790,877	1,241,857	2,032,734	0	2,032,734	50.00
51.00	05100	349,807	117,227	467,034	0	467,034	51.00
53.00	05300	0	803,633	803,633	0	803,633	53.00
54.00	05400	1,605,259	1,356,260	2,961,519	0	2,961,519	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	792,838	1,584,167	2,377,005	0	2,377,005	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,030,358	316,977	1,347,335	0	1,347,335	65.00
66.00	06600	635,206	175,150	810,356	0	810,356	66.00
67.00	06700	180,891	49,633	230,524	0	230,524	67.00
68.00	06800	69,947	16,314	86,261	0	86,261	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	1,068,999	1,068,999	0	1,068,999	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	895,011	2,084,322	2,979,333	0	2,979,333	91.00
92.00	09200						92.00
93.00	04040	2,211,314	687,730	2,899,044	0	2,899,044	93.00
93.01	04951	2,253,199	290,305	2,543,504	0	2,543,504	93.01
93.02	04950	1,991,847	299,098	2,290,945	0	2,290,945	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		0	0	0	0	113.00
118.00		20,146,676	25,071,467	45,218,143	92,184	45,310,327	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	3,841,598	1,617,487	5,459,085	0	5,459,085	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	58,087	257,362	315,449	-92,184	223,265	194.00
200.00		24,046,361	26,946,316	50,992,677	0	50,992,677	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-36,525	2,247,162	1.00
1.02	00102	AKRON BUILDING	0	47,608	1.02
1.03	00103	ARGOS BUILDING	0	84,274	1.03
1.04	00101	CLAYS BUILDING	0	120,144	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,935	4,166,140	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-249,536	4,800,636	5.00
7.00	00700	OPERATION OF PLANT	0	1,543,074	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	112,368	8.00
9.00	00900	HOUSEKEEPING	0	460,322	9.00
10.00	01000	DIETARY	-24,488	222,080	10.00
11.00	01100	CAFETERIA	-120,934	309,165	11.00
13.00	01300	NURSING ADMINISTRATION	0	201,362	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-510,226	2,891,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	854,006	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	2,796,822	30.00
31.00	03100	INTENSIVE CARE UNIT	0	604,329	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-1,530	2,031,204	50.00
51.00	05100	RECOVERY ROOM	0	467,034	51.00
53.00	05300	ANESTHESIOLOGY	-748,250	55,383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-169,082	2,792,437	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	2,377,005	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-18,379	1,328,956	65.00
66.00	06600	PHYSICAL THERAPY	-71,597	738,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	230,524	67.00
68.00	06800	SPEECH PATHOLOGY	-4,438	81,823	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,068,999	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-1,381,465	1,597,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	ROCHESTER MEDICAL	-1,777,841	1,121,203	93.00
93.01	04951	ROCHESTER ORTHO	-2,107,100	436,404	93.01
93.02	04950	ROCHESTER SURGICAL	-2,124,355	166,590	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,354,681	35,955,646	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
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	5,459,085	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	ADVERTISING	0	223,265	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-9,354,681	41,637,996	200.00

RECLASSIFICATIONS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-6  
Date/Time Prepared:  
4/13/2016 9:17 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	233,193	196,906	1.00
	O		233,193	196,906	
B - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	16,975	75,209	1.00
	O		16,975	75,209	
C - DEPRECIATION					
1.00	CLAYS BUILDING	1.04	0	107,575	1.00
	O		0	107,575	
500.00	Grand Total: Increases		250,168	379,690	500.00

RECLASSIFICATIONS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-6

Date/Time Prepared:  
4/13/2016 9:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	233,193	196,906	0		1.00
	O		233,193	196,906			
B - ADVERTISING							
1.00	ADVERTISING	194.00	16,975	75,209	0		1.00
	O		16,975	75,209			
C - DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	107,575	9		1.00
	O		0	107,575			
500.00	Grand Total: Decreases		250,168	379,690			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	596,216	0	0	0	0	1.00
2.00	Land Improvements	479,597	10,050	0	10,050	0	2.00
3.00	Buildings and Fixtures	26,117,323	700,396	0	700,396	5,903	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,286,422	1,473,152	0	1,473,152	336,165	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,479,558	2,183,598	0	2,183,598	342,068	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,479,558	2,183,598	0	2,183,598	342,068	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	596,216	0				1.00
2.00	Land Improvements	489,647	0				2.00
3.00	Buildings and Fixtures	26,811,816	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,423,409	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	37,321,088	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	37,321,088	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part II  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,259,458	0	657,643	452,918	21,243	1.00
1.02	AKRON BUILDING	28,966	0	0	0	10,349	1.02
1.03	ARGOS BUILDING	51,324	0	0	0	15,433	1.03
1.04	CLAYS BUILDING	0	0	0	0	12,569	1.04
3.00	Total (sum of lines 1-2)	1,339,748	0	657,643	452,918	59,594	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,391,262				1.00
1.02	AKRON BUILDING	8,293	47,608				1.02
1.03	ARGOS BUILDING	17,517	84,274				1.03
1.04	CLAYS BUILDING	0	12,569				1.04
3.00	Total (sum of lines 1-2)	25,810	2,535,713				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-7  
Part III  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	35,232,376	0	35,232,376	0.944034	0	1.00
1.02	AKRON BUILDING	764,597	0	764,597	0.020487	0	1.02
1.03	ARGOS BUILDING	1,324,115	0	1,324,115	0.035479	0	1.03
1.04	CLAYS BUILDING	0	0	0	0.000000	0	1.04
3.00	Total (sum of lines 1-2)	37,321,088	0	37,321,088	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,129,722	0	1.00
1.02	AKRON BUILDING	0	0	0	28,966	0	1.02
1.03	ARGOS BUILDING	0	0	0	51,324	0	1.03
1.04	CLAYS BUILDING	0	0	0	107,575	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,317,587	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	643,279	452,918	21,243	0	2,247,162	1.00
1.02	AKRON BUILDING	0	0	10,349	8,293	47,608	1.02
1.03	ARGOS BUILDING	0	0	15,433	17,517	84,274	1.03
1.04	CLAYS BUILDING	0	0	12,569	0	120,144	1.04
3.00	Total (sum of lines 1-2)	643,279	452,918	59,594	25,810	2,499,188	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8

Date/Time Prepared:  
4/13/2016 9:17 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
				Cost Center		Line #	
				1.00	2.00	3.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
1.02	Investment income - AKRON BUILDING (chapter 2)			0	AKRON BUILDING	1.02	0 1.02
1.03	Investment income - ARGOS BUILDING (chapter 2)			0	ARGOS BUILDING	1.03	0 1.03
1.04	Investment income - CLAYS BUILDING (chapter 2)			0	CLAYS BUILDING	1.04	0 1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0 2.00
3.00	Investment income - other (chapter 2)			0		0.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0		0.00	0 7.00
8.00	Television and radio service (chapter 21)			0		0.00	0 8.00
9.00	Parking lot (chapter 21)			0		0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-7,561,373	0			0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0		0.00	0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0			0 12.00
13.00	Laundry and linen service			0		0.00	0 13.00
14.00	Cafeteria-employees and guests			0		0.00	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 supplies to other than patients			0		0.00	0 16.00
17.00	Sale of drugs to other than patients			0		0.00	0 17.00
18.00	Sale of medical records and abstracts			0		0.00	0 18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00	0 19.00
20.00	Vending machines			0		0.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
26.02	Depreciation - AKRON BUILDING			0	AKRON BUILDING	1.02	0 26.02
26.03	Depreciation - ARGOS BUILDING			0	ARGOS BUILDING	1.03	0 26.03
26.04	Depreciation - CLAYS BUILDING			0	CLAYS BUILDING	1.04	0 26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant			0		0.00	0 29.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-22,161		NEW CAP REL COSTS-BLDG & FIXT	1.00	9 32.00
33.00 PHYSICIAN RECRUITMENT	A	-46,020		ADMINISTRATIVE & GENERAL	5.00	0 33.00
34.00 PHYSICIAN RECRUITMENT	A	-8,935		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 34.00
35.00 ANESTHESIA OFFSET	A	-748,250		ANESTHESIOLOGY	53.00	0 35.00
36.00 HAF EXPENSE	A	-99,100		ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 OTHER INCOME -INT INCOME	B	-14,201		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 37.00
38.00 SAVINGS -INT INCOME	B	-163		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 38.00
39.00 EDUCATION OTHER REVENUE	B	-2,739		ADMINISTRATIVE & GENERAL	5.00	0 39.00
41.00 CLERICAL FEES -HIM	B	-28,990		ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 CHAPLAIN - OTHER REVENUE	B	-900		ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00 SUPPLY SALES	B	-2,117		ADMINISTRATIVE & GENERAL	5.00	0 43.00
44.00 HOME MEAL PROGRAM	B	-15,528		DIETARY	10.00	0 44.00
45.01 DIETARY SPEC EVENTS	B	-8,960		DIETARY	10.00	0 45.01
45.02 HOUSEKEEPING VENDING-OTH REV	B	-33		CAFETERIA	11.00	0 45.02
45.03 CAFETERIA SALES	B	-120,901		CAFETERIA	11.00	0 45.03
45.04 DRUG SALES	B	-510,226		PHARMACY	15.00	0 45.04
45.05 RESPIRATORY OTHER REV	B	-18,379		RESPIRATORY THERAPY	65.00	0 45.05
45.06 PT - OTHER REVENUE	B	-3,267		PHYSICAL THERAPY	66.00	0 45.06
45.07 OCC THER OTH REV	B	-53,330		PHYSICAL THERAPY	66.00	0 45.07
45.08 ATHLETIC TRAINING -OTH REV	B	-15,000		PHYSICAL THERAPY	66.00	0 45.08
45.09 SPEECH THERAPY- OTH REVENUE	B	-4,438		SPEECH PATHOLOGY	68.00	0 45.09
45.10 MISC REV -OTH REV	B	-65,894		ADMINISTRATIVE & GENERAL	5.00	0 45.10
45.11 IHA AND AHA LOBBYING	A	-3,776		ADMINISTRATIVE & GENERAL	5.00	0 45.11
45.12		0			0.00	0 45.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,354,681				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet A-8-2

Date/Time Prepared:  
4/13/2016 9:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	1,530	1,530	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	169,082	169,082	0	0	0	2.00
3.00	60.00	LABORATORY	24,996	0	24,996	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	5,625	0	5,625	0	0	4.00
5.00	91.00	EMERGENCY	1,745,992	1,381,465	364,527	0	0	5.00
6.00	93.00	ROCHESTER MEDICAL	1,777,841	1,777,841	0	0	0	6.00
7.00	93.01	ROCHESTER ORTHO	2,107,100	2,107,100	0	0	0	7.00
8.00	93.02	ROCHESTER SURGICAL	2,124,355	2,124,355	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,956,521	7,561,373	395,148	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	93.00	ROCHESTER MEDICAL	0	0	0	0	0	6.00
7.00	93.01	ROCHESTER ORTHO	0	0	0	0	0	7.00
8.00	93.02	ROCHESTER SURGICAL	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	1,530	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	169,082	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	1,381,465	5.00
6.00	93.00	ROCHESTER MEDICAL	0	0	0	1,777,841	6.00
7.00	93.01	ROCHESTER ORTHO	0	0	0	2,107,100	7.00
8.00	93.02	ROCHESTER SURGICAL	0	0	0	2,124,355	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	7,561,373	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING		
		1.00	1.02	1.03	1.04		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,247,162	2,247,162				1.00	
1.02 00102 AKRON BUILDING	47,608	0	47,608			1.02	
1.03 00103 ARGOS BUILDING	84,274	0	0	84,274		1.03	
1.04 00101 CLAYS BUILDING	120,144	0	0	0	120,144	1.04	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4,166,140	9,393	0	0	0	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	4,800,636	254,990	5,441	6,742	94	5.00	
7.00 00700 OPERATION OF PLANT	1,543,074	210,380	3,265	7,686	51,017	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	112,368	9,232	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	460,322	23,049	0	0	259	9.00	
10.00 01000 DIETARY	222,080	39,904	0	0	877	10.00	
11.00 01100 CAFETERIA	309,165	69,610	0	0	0	11.00	
13.00 01300 NURSING ADMINISTRATION	201,362	53,058	0	0	0	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00	
15.00 01500 PHARMACY	2,891,965	22,888	0	0	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	854,006	21,480	0	0	3,243	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	2,796,822	335,120	0	0	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	604,329	47,788	0	0	0	31.00	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	2,031,204	157,342	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	467,034	15,205	0	0	0	51.00	
53.00 05300 ANESTHESIOLOGY	55,383	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,792,437	275,726	0	0	0	54.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	2,377,005	55,210	0	0	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	1,328,956	106,537	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	738,759	68,685	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	230,524	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	81,823	0	0	0	0	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,068,999	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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	
91.00 09100 EMERGENCY	1,597,868	191,896	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00 04040 ROCHESTER MEDICAL	1,121,203	225,545	0	0	21,991	93.00	
93.01 04951 ROCHESTER ORTHO	436,404	0	0	0	33,981	93.01	
93.02 04950 ROCHESTER SURGICAL	166,590	48,774	0	0	0	93.02	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,955,646	2,241,812	8,706	14,428	111,462	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5,459,085	0	38,902	69,846	8,682	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 ADVERTISING	223,265	5,350	0	0	0	194.00	
200.00	Cross Foot Adjustments	0	0	0	0	200.00	
201.00	Negative Cost Centers	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	41,637,996	2,247,162	47,608	84,274	120,144	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period: From 01/01/2015 To 12/31/2015

Worksheet B Part I Date/Time Prepared: 4/13/2016 9:17 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
		4.00	4A	5.00	7.00	8.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.02	00102	AKRON BUILDING					1.02	
1.03	00103	ARGOS BUILDING					1.03	
1.04	00101	CLAYS BUILDING					1.04	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,175,533				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	446,929	5,514,832	5,514,832		5.00	
7.00	00700	OPERATION OF PLANT	57,430	1,872,852	285,923	2,158,775	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,877	123,477	18,851	9,924	152,252	8.00
9.00	00900	HOUSEKEEPING	55,048	538,678	82,238	25,728	15,225	9.00
10.00	01000	DIETARY	23,391	286,252	43,701	46,115	1,512	10.00
11.00	01100	CAFETERIA	40,802	419,577	64,056	74,827	0	11.00
13.00	01300	NURSING ADMINISTRATION	27,437	281,857	43,030	57,033	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	50,654	2,965,507	452,735	24,604	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,925	985,654	150,477	35,003	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	367,021	3,498,963	534,176	360,232	48,700	30.00
31.00	03100	INTENSIVE CARE UNIT	77,849	729,966	111,442	51,369	7,613	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	138,382	2,326,928	355,245	169,133	27,426	50.00
51.00	05100	RECOVERY ROOM	61,207	543,446	82,966	16,345	7,613	51.00
53.00	05300	ANESTHESIOLOGY	0	55,383	8,455	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,877	3,349,040	511,288	296,388	12,200	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	138,725	2,570,940	392,498	59,347	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	180,285	1,615,778	246,676	114,521	7,613	65.00
66.00	06600	PHYSICAL THERAPY	111,144	918,588	140,238	73,832	3,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,651	262,175	40,025	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,239	94,062	14,360	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,068,999	163,201	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
91.00	09100	EMERGENCY	156,603	1,946,367	297,146	206,276	21,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	386,920	1,755,659	268,031	323,218	0	93.00
93.01	04951	ROCHESTER ORTHO	394,249	864,634	132,001	124,812	0	93.01
93.02	04950	ROCHESTER SURGICAL	348,519	563,883	86,086	52,428	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,496,164	35,153,497	4,524,845	2,121,135	152,252	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
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	672,176	6,248,691	953,987	31,889	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	7,193	235,808	36,000	5,751	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,175,533	41,637,996	5,514,832	2,158,775	152,252	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102 AKRON BUILDING						1.02
1.03	00103 ARGOS BUILDING						1.03
1.04	00101 CLAYS BUILDING						1.04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	661,869					9.00
10.00	01000 DIETARY	2,731	380,311				10.00
11.00	01100 CAFETERIA	8,850	0	567,310			11.00
13.00	01300 NURSING ADMINISTRATION	1,967	0	4,289	388,176		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	6,173	0	15,190	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	5,299	0	37,838	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	146,710	357,584	106,518	302,814	0	30.00
31.00	03100 INTENSIVE CARE UNIT	31,629	22,727	17,979	51,091	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	77,844	0	54,253	0	0	50.00
51.00	05100 RECOVERY ROOM	53,098	0	15,781	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	69,541	0	61,246	34,271	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	23,271	0	40,330	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	30,154	0	41,366	0	0	65.00
66.00	06600 PHYSICAL THERAPY	15,569	0	31,584	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
91.00	09100 EMERGENCY	74,348	0	38,007	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 ROCHESTER MEDICAL	81,996	0	56,197	0	0	93.00
93.01	04951 ROCHESTER ORTHO	26,221	0	29,683	0	0	93.01
93.02	04950 ROCHESTER SURGICAL	5,463	0	15,443	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910 CORF	0	0	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	660,864	380,311	565,704	388,176	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 ADVERTISING	1,005	0	1,606	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	661,869	380,311	567,310	388,176	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	3,464,209				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,214,271			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	73,811	5,429,508	0	5,429,508
31.00	03100	INTENSIVE CARE UNIT	0	16,691	1,040,507	0	1,040,507
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	157,749	3,168,578	0	3,168,578
51.00	05100	RECOVERY ROOM	0	19,841	739,090	0	739,090
53.00	05300	ANESTHESIOLOGY	0	20,756	84,594	0	84,594
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	280,566	4,614,540	0	4,614,540
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	232,911	3,319,297	0	3,319,297
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	90,943	2,147,051	0	2,147,051
66.00	06600	PHYSICAL THERAPY	0	21,389	1,204,225	0	1,204,225
67.00	06700	OCCUPATIONAL THERAPY	0	7,357	309,557	0	309,557
68.00	06800	SPEECH PATHOLOGY	0	1,740	110,162	0	110,162
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,625	1,252,825	0	1,252,825
73.00	07300	DRUGS CHARGED TO PATIENTS	3,464,209	170,834	3,635,043	0	3,635,043
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
91.00	09100	EMERGENCY	0	80,576	2,664,045	0	2,664,045
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	0	13,551	2,498,652	0	2,498,652
93.01	04951	ROCHESTER ORTHO	0	3,378	1,180,729	0	1,180,729
93.02	04950	ROCHESTER SURGICAL	0	1,553	724,856	0	724,856
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,464,209	1,214,271	34,123,259	0	34,123,259
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	7,234,567	0	7,234,567
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	280,170	0	280,170
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,464,209	1,214,271	41,637,996	0	41,637,996

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
		1.00	1.02	1.03	1.04	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02 00102	AKRON BUILDING					1.02
1.03 00103	ARGOS BUILDING					1.03
1.04 00101	CLAYS BUILDING					1.04
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,393	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	254,990	5,441	6,742	94
7.00 00700	OPERATION OF PLANT	0	210,380	3,265	7,686	51,017
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,232	0	0	0
9.00 00900	HOUSEKEEPING	0	23,049	0	0	259
10.00 01000	DIETARY	0	39,904	0	0	877
11.00 01100	CAFETERIA	0	69,610	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	53,058	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	22,888	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	21,480	0	0	3,243
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	335,120	0	0	0
31.00 03100	INTENSIVE CARE UNIT	0	47,788	0	0	0
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	157,342	0	0	0
51.00 05100	RECOVERY ROOM	0	15,205	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	275,726	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	0	55,210	0	0	0
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	106,537	0	0	0
66.00 06600	PHYSICAL THERAPY	0	68,685	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	0	191,896	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 04040	ROCHESTER MEDICAL	0	225,545	0	0	21,991
93.01 04951	ROCHESTER ORTHO	0	0	0	0	33,981
93.02 04950	ROCHESTER SURGICAL	0	48,774	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,241,812	8,706	14,428	111,462
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	38,902	69,846	8,682
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	ADVERTISING	0	5,350	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	2,247,162	47,608	84,274	120,144

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
		2A	4.00	5.00	7.00	8.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.02	00102	AKRON BUILDING					1.02	
1.03	00103	ARGOS BUILDING					1.03	
1.04	00101	CLAYS BUILDING					1.04	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,393	9,393			4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	267,267	1,006	268,273		5.00	
7.00	00700	OPERATION OF PLANT	272,348	129	13,910	286,387	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	9,232	4	917	1,316	8.00	
9.00	00900	HOUSEKEEPING	23,308	124	4,001	3,413	1,147	9.00
10.00	01000	DIETARY	40,781	53	2,126	6,118	114	10.00
11.00	01100	CAFETERIA	69,610	92	3,116	9,927	0	11.00
13.00	01300	NURSING ADMINISTRATION	53,058	62	2,093	7,566	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	22,888	114	22,025	3,264	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,723	241	7,320	4,644	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	335,120	826	25,987	47,788	3,670	30.00
31.00	03100	INTENSIVE CARE UNIT	47,788	175	5,421	6,815	573	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	157,342	312	17,282	22,437	2,066	50.00
51.00	05100	RECOVERY ROOM	15,205	138	4,036	2,168	573	51.00
53.00	05300	ANESTHESIOLOGY	0	0	411	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	275,726	632	24,873	39,319	919	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	55,210	312	19,094	7,873	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	106,537	406	12,000	15,193	573	65.00
66.00	06600	PHYSICAL THERAPY	68,685	250	6,822	9,795	228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	71	1,947	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	28	699	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	7,939	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
91.00	09100	EMERGENCY	191,896	353	14,456	27,365	1,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	247,536	871	13,039	42,879	0	93.00
93.01	04951	ROCHESTER ORTHO	33,981	888	6,422	16,558	0	93.01
93.02	04950	ROCHESTER SURGICAL	48,774	785	4,188	6,955	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,376,408	7,872	220,124	281,393	11,469	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
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	117,430	1,505	46,398	4,231	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	5,350	16	1,751	763	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,499,188	9,393	268,273	286,387	11,469	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.02	00102						1.02
1.03	00103						1.03
1.04	00101						1.04
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	31,993					9.00
10.00	01000	132	49,324				10.00
11.00	01100	428	0	83,173			11.00
13.00	01300	95	0	629	63,503		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	298	0	2,227	0	0	15.00
16.00	01600	256	0	5,547	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	7,091	46,376	15,616	49,539	0	30.00
31.00	03100	1,529	2,948	2,636	8,358	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,763	0	7,954	0	0	50.00
51.00	05100	2,567	0	2,314	0	0	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	3,361	0	8,979	5,606	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,125	0	5,913	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,458	0	6,065	0	0	65.00
66.00	06600	753	0	4,631	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	3,594	0	5,572	0	0	91.00
92.00	09200						92.00
93.00	04040	3,963	0	8,239	0	0	93.00
93.01	04951	1,267	0	4,352	0	0	93.01
93.02	04950	264	0	2,264	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		31,944	49,324	82,938	63,503	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	49	0	235	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		31,993	49,324	83,173	63,503	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B  
Part II  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.02	00102						1.02
1.03	00103						1.03
1.04	00101						1.04
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	50,816					15.00
16.00	01600		42,731				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	2,599	534,612	0	534,612	30.00
31.00	03100	0	588	76,831	0	76,831	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	5,554	216,710	0	216,710	50.00
51.00	05100	0	699	27,700	0	27,700	51.00
53.00	05300	0	731	1,142	0	1,142	53.00
54.00	05400	0	9,856	369,271	0	369,271	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	8,200	97,727	0	97,727	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	3,202	145,434	0	145,434	65.00
66.00	06600	0	753	91,917	0	91,917	66.00
67.00	06700	0	259	2,277	0	2,277	67.00
68.00	06800	0	61	788	0	788	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	726	8,665	0	8,665	72.00
73.00	07300	50,816	6,015	56,831	0	56,831	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	2,837	247,679	0	247,679	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	477	317,004	0	317,004	93.00
93.01	04951	0	119	63,587	0	63,587	93.01
93.02	04950	0	55	63,285	0	63,285	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		50,816	42,731	2,321,460	0	2,321,460	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	169,564	0	169,564	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	8,164	0	8,164	194.00
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		50,816	42,731	2,499,188	0	2,499,188	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		
		NEW BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)			
		1.00	1.02	1.03	1.04			4.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	111,728					1.00
1.02	00102	AKRON BUILDING	0	3,500				1.02
1.03	00103	ARGOS BUILDING	0	0	7,500			1.03
1.04	00101	CLAYS BUILDING	0	0	0	20,411		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	467	0	0	0	23,863,881	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,678	400	600	16	2,554,274	5.00
7.00	00700	OPERATION OF PLANT	10,460	240	684	8,667	328,222	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	459	0	0	0	10,729	8.00
9.00	00900	HOUSEKEEPING	1,146	0	0	44	314,611	9.00
10.00	01000	DIETARY	1,984	0	0	149	133,685	10.00
11.00	01100	CAFETERIA	3,461	0	0	0	233,193	11.00
13.00	01300	NURSING ADMINISTRATION	2,638	0	0	0	156,808	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,138	0	0	0	289,498	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,068	0	0	551	611,092	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	16,662	0	0	0	2,097,586	30.00
31.00	03100	INTENSIVE CARE UNIT	2,376	0	0	0	444,919	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	7,823	0	0	0	790,877	50.00
51.00	05100	RECOVERY ROOM	756	0	0	0	349,807	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,709	0	0	0	1,605,259	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,745	0	0	0	792,838	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,297	0	0	0	1,030,358	65.00
66.00	06600	PHYSICAL THERAPY	3,415	0	0	0	635,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	180,891	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	69,947	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
91.00	09100	EMERGENCY	9,541	0	0	0	895,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	11,214	0	0	3,736	2,211,314	93.00
93.01	04951	ROCHESTER ORTHO	0	0	0	5,773	2,253,199	93.01
93.02	04950	ROCHESTER SURGICAL	2,425	0	0	0	1,991,847	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	111,462	640	1,284	18,936	19,981,171	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,860	6,216	1,475	3,841,598	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	266	0	0	0	41,112	194.00
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)	2,247,162	47,608	84,274	120,144	4,175,533	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.112792	13.602286	11.236533	5.886238	0.174973	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,393	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000394	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1

Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)		
		5A	5.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.02	00102	AKRON BUILDING					1.02	
1.03	00103	ARGOS BUILDING					1.03	
1.04	00101	CLAYS BUILDING					1.04	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	-5,514,832	36,123,164			5.00	
7.00	00700	OPERATION OF PLANT	0	1,872,852	99,851		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,477	459	3,020	8.00	
9.00	00900	HOUSEKEEPING	0	538,678	1,190	302	60,580	9.00
10.00	01000	DIETARY	0	286,252	2,133	30	250	10.00
11.00	01100	CAFETERIA	0	419,577	3,461	0	810	11.00
13.00	01300	NURSING ADMINISTRATION	0	281,857	2,638	0	180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	2,965,507	1,138	0	565	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	985,654	1,619	0	485	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	3,498,963	16,662	966	13,428	30.00
31.00	03100	INTENSIVE CARE UNIT	0	729,966	2,376	151	2,895	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	2,326,928	7,823	544	7,125	50.00
51.00	05100	RECOVERY ROOM	0	543,446	756	151	4,860	51.00
53.00	05300	ANESTHESIOLOGY	0	55,383	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,349,040	13,709	242	6,365	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,570,940	2,745	0	2,130	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,615,778	5,297	151	2,760	65.00
66.00	06600	PHYSICAL THERAPY	0	918,588	3,415	60	1,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	262,175	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	94,062	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,068,999	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
91.00	09100	EMERGENCY	0	1,946,367	9,541	423	6,805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	0	1,755,659	14,950	0	7,505	93.00
93.01	04951	ROCHESTER ORTHO	0	864,634	5,773	0	2,400	93.01
93.02	04950	ROCHESTER SURGICAL	0	563,883	2,425	0	500	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,514,832	29,638,665	98,110	3,020	60,488	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,248,691	1,475	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	235,808	266	0	92	194.00
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)		5,514,832	2,158,775	152,252	661,869	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.152667	21.619964	50.414570	10.925536	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		268,273	286,387	11,469	31,993	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007427	2.868144	3.797682	0.528112	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.02	00102						1.02
1.03	00103						1.03
1.04	00101						1.04
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	4,083					10.00
11.00	01100	0	26,853				11.00
13.00	01300	0	203	134,426			13.00
14.00	01400	0	0	0	1,523,799		14.00
15.00	01500	0	719	0	0	100	15.00
16.00	01600	0	1,791	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,839	5,042	104,865	53,687	0	30.00
31.00	03100	244	851	17,693	25,258	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	2,568	0	774,941	0	50.00
51.00	05100	0	747	0	51,911	0	51.00
53.00	05300	0	0	0	21,897	0	53.00
54.00	05400	0	2,899	11,868	65,923	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	1,909	0	4,586	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	1,958	0	21,373	0	65.00
66.00	06600	0	1,495	0	11,612	0	66.00
67.00	06700	0	0	0	46	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	100	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	1,799	0	80,448	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	2,660	0	46,831	0	93.00
93.01	04951	0	1,405	0	25,581	0	93.01
93.02	04950	0	731	0	61,910	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		4,083	26,777	134,426	1,246,004	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	277,795	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	76	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		380,311	567,310	388,176	0	3,464,209	202.00
203.00		93.144991	21.126504	2.887656	0.000000	34,642.090000	203.00
204.00		49,324	83,173	63,503	0	50,816	204.00
205.00		12.080333	3.097345	0.472401	0.000000	508.160000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet B-1  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
1.02	00102	AKRON BUILDING	1.02
1.03	00103	ARGOS BUILDING	1.03
1.04	00101	CLAYS BUILDING	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		103,267,234	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
		6,277,013	
		1,419,410	
		0	
		0	
		0	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		13,415,213	
		1,687,324	
		1,765,081	
		23,863,727	
		0	
		0	
		0	
		19,807,081	
		0	
		7,733,900	
		1,818,972	
		625,660	
		147,971	
		0	
		1,753,980	
		14,527,913	
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04040	ROCHESTER MEDICAL	93.00
93.01	04951	ROCHESTER ORTHO	93.01
93.02	04950	ROCHESTER SURGICAL	93.02
		6,852,286	
		1,152,416	
		287,246	
		132,041	
<b>OTHER REIMBURSABLE COST CENTERS</b>			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
		0	
		0	
		0	
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		103,267,234	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	ADVERTISING	194.00
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)	202.00
		1,214,271	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.011759	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		42,731	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000414	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	5,429,508		5,429,508	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	1,040,507		1,040,507	0	0 31.00
41.00	04100 SUBPROVIDER - I RF	0		0	0	0 41.00
42.00	04200 SUBPROVIDER	0		0	0	0 42.00
43.00	04300 NURSERY	0		0	0	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	3,168,578		3,168,578	0	0 50.00
51.00	05100 RECOVERY ROOM	739,090		739,090	0	0 51.00
53.00	05300 ANESTHESIOLOGY	84,594		84,594	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,614,540		4,614,540	0	0 54.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	3,319,297		3,319,297	0	0 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	2,147,051	0	2,147,051	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,204,225	0	1,204,225	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	309,557	0	309,557	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	110,162	0	110,162	0	0 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,252,825		1,252,825	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,635,043		3,635,043	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
91.00	09100 EMERGENCY	2,664,045		2,664,045	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,007,968		1,007,968	0	0 92.00
93.00	04040 ROCHESTER MEDICAL	2,498,652		2,498,652	0	0 93.00
93.01	04951 ROCHESTER ORTHO	1,180,729		1,180,729	0	0 93.01
93.02	04950 ROCHESTER SURGICAL	724,856		724,856	0	0 93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
99.10	09910 CORF	0		0	0	0 99.10
101.00	10100 HOME HEALTH AGENCY	0		0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	35,131,227	0	35,131,227	0	0 200.00
201.00	Less Observation Beds	1,007,968		1,007,968		0 201.00
202.00	Total (see instructions)	34,123,259	0	34,123,259	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	4,962,228		4,962,228		30.00
31.00	03100	INTENSIVE CARE UNIT	1,419,410		1,419,410		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,466,178	9,949,035	13,415,213	0.236193	50.00
51.00	05100	RECOVERY ROOM	344,173	1,343,151	1,687,324	0.438025	51.00
53.00	05300	ANESTHESIOLOGY	243,209	1,521,872	1,765,081	0.047926	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,289,309	22,574,418	23,863,727	0.193370	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,638,877	17,168,204	19,807,081	0.167581	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,439,982	5,293,918	7,733,900	0.277616	65.00
66.00	06600	PHYSICAL THERAPY	290,444	1,528,528	1,818,972	0.662036	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,365	524,295	625,660	0.494769	67.00
68.00	06800	SPEECH PATHOLOGY	25,614	122,357	147,971	0.744484	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,484,543	269,437	1,753,980	0.714276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,705,309	10,822,604	14,527,913	0.250211	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	141,156	6,711,130	6,852,286	0.388782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,314,785	1,314,785	0.766641	92.00
93.00	04040	ROCHESTER MEDICAL	16,543	1,135,873	1,152,416	2.168186	93.00
93.01	04951	ROCHESTER ORTHO	2,556	284,690	287,246	4.110515	93.01
93.02	04950	ROCHESTER SURGICAL	1,280	130,761	132,041	5.489628	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	22,572,176	80,695,058	103,267,234		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	22,572,176	80,695,058	103,267,234		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 4/13/2016 9:17 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 ROCHESTER MEDICAL	0.000000		93.00
93.01	04951 ROCHESTER ORTHO	0.000000		93.01
93.02	04950 ROCHESTER SURGICAL	0.000000		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		5,429,508	0	5,429,508	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,040,507	0	1,040,507	31.00	
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00	
42.00	04200 SUBPROVIDER		0	0	0	42.00	
43.00	04300 NURSERY		0	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		3,168,578	0	3,168,578	50.00	
51.00	05100 RECOVERY ROOM		739,090	0	739,090	51.00	
53.00	05300 ANESTHESIOLOGY		84,594	0	84,594	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,614,540	0	4,614,540	54.00	
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 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		3,319,297	0	3,319,297	60.00	
60.01	06001 BLOOD LABORATORY		0	0	0	60.01	
65.00	06500 RESPIRATORY THERAPY	0	2,147,051	0	2,147,051	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,204,225	0	1,204,225	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	309,557	0	309,557	67.00	
68.00	06800 SPEECH PATHOLOGY	0	110,162	0	110,162	68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,252,825	0	1,252,825	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		3,635,043	0	3,635,043	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
91.00	09100 EMERGENCY		2,664,045	0	2,664,045	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,007,968	0	1,007,968	92.00	
93.00	04040 ROCHESTER MEDICAL		2,498,652	0	2,498,652	93.00	
93.01	04951 ROCHESTER ORTHO		1,180,729	0	1,180,729	93.01	
93.02	04950 ROCHESTER SURGICAL		724,856	0	724,856	93.02	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0	0	0	96.00	
99.10	09910 CORF		0	0	0	99.10	
101.00	10100 HOME HEALTH AGENCY		0	0	0	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		35,131,227	0	35,131,227	200.00	
201.00	Less Observation Beds		1,007,968		1,007,968	201.00	
202.00	Total (see instructions)		34,123,259	0	34,123,259	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet C  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

			Title XIX			Hospital		Cost	
Cost Center Description	Charges			Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient							
	6.00	7.00	8.00						
			9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	4,962,228		4,962,228				30.00
31.00	03100	INTENSIVE CARE UNIT	1,419,410		1,419,410				31.00
41.00	04100	SUBPROVIDER - IRF	0		0				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	0		0				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	3,466,178	9,949,035	13,415,213	0.236193	0.000000		50.00
51.00	05100	RECOVERY ROOM	344,173	1,343,151	1,687,324	0.438025	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	243,209	1,521,872	1,765,081	0.047926	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,289,309	22,574,418	23,863,727	0.193370	0.000000		54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	2,638,877	17,168,204	19,807,081	0.167581	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	2,439,982	5,293,918	7,733,900	0.277616	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	290,444	1,528,528	1,818,972	0.662036	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	101,365	524,295	625,660	0.494769	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	25,614	122,357	147,971	0.744484	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,484,543	269,437	1,753,980	0.714276	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,705,309	10,822,604	14,527,913	0.250211	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000		89.00
91.00	09100	EMERGENCY	141,156	6,711,130	6,852,286	0.388782	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,314,785	1,314,785	0.766641	0.000000		92.00
93.00	04040	ROCHESTER MEDICAL	16,543	1,135,873	1,152,416	2.168186	0.000000		93.00
93.01	04951	ROCHESTER ORTHO	2,556	284,690	287,246	4.110515	0.000000		93.01
93.02	04950	ROCHESTER SURGICAL	1,280	130,761	132,041	5.489628	0.000000		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000		96.00
99.10	09910	CORF	0	0	0				99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	22,572,176	80,695,058	103,267,234				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	22,572,176	80,695,058	103,267,234				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 4/13/2016 9:17 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 ROCHESTER MEDICAL	0.000000		93.00
93.01	04951 ROCHESTER ORTHO	0.000000		93.01
93.02	04950 ROCHESTER SURGICAL	0.000000		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 4/13/2016 9:17 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	216,710	13,415,213	0.016154	950,963	15,362	50.00
51.00	05100 RECOVERY ROOM	27,700	1,687,324	0.016417	79,302	1,302	51.00
53.00	05300 ANESTHESIOLOGY	1,142	1,765,081	0.000647	64,932	42	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	369,271	23,863,727	0.015474	497,943	7,705	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	97,727	19,807,081	0.004934	988,910	4,879	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	145,434	7,733,900	0.018805	1,192,492	22,425	65.00
66.00	06600 PHYSICAL THERAPY	91,917	1,818,972	0.050532	132,283	6,685	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,277	625,660	0.003639	38,433	140	67.00
68.00	06800 SPEECH PATHOLOGY	788	147,971	0.005325	17,143	91	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,665	1,753,980	0.004940	638,001	3,152	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	56,831	14,527,913	0.003912	1,408,346	5,509	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	247,679	6,852,286	0.036145	371	13	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	101,438	1,314,785	0.077152	0	0	92.00
93.00	04040 ROCHESTER MEDICAL	317,004	1,152,416	0.275078	0	0	93.00
93.01	04951 ROCHESTER ORTHO	63,587	287,246	0.221368	0	0	93.01
93.02	04950 ROCHESTER SURGICAL	63,285	132,041	0.479283	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	1,811,455	96,885,596		6,009,119	67,305	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	0	0	0	0	0	0	93.00
93.01	04951	ROCHESTER ORTHO	0	0	0	0	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	0	0	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 4/13/2016 9:17 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	13,415,213	0.000000	0.000000	950,963	50.00
51.00	05100 RECOVERY ROOM	0	1,687,324	0.000000	0.000000	79,302	51.00
53.00	05300 ANESTHESIOLOGY	0	1,765,081	0.000000	0.000000	64,932	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	23,863,727	0.000000	0.000000	497,943	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	19,807,081	0.000000	0.000000	988,910	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	7,733,900	0.000000	0.000000	1,192,492	65.00
66.00	06600 PHYSICAL THERAPY	0	1,818,972	0.000000	0.000000	132,283	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	625,660	0.000000	0.000000	38,433	67.00
68.00	06800 SPEECH PATHOLOGY	0	147,971	0.000000	0.000000	17,143	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,753,980	0.000000	0.000000	638,001	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14,527,913	0.000000	0.000000	1,408,346	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	6,852,286	0.000000	0.000000	371	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,314,785	0.000000	0.000000	0	92.00
93.00	04040 ROCHESTER MEDICAL	0	1,152,416	0.000000	0.000000	0	93.00
93.01	04951 ROCHESTER ORTHO	0	287,246	0.000000	0.000000	0	93.01
93.02	04950 ROCHESTER SURGICAL	0	132,041	0.000000	0.000000	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	96,885,596			6,009,119	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 4/13/2016 9:17 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 ROCHESTER MEDICAL	0	0	0		93.00
93.01	04951 ROCHESTER ORTHO	0	0	0		93.01
93.02	04950 ROCHESTER SURGICAL	0	0	0		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 4/13/2016 9:17 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.236193	0	1,327,945	0	0
51.00 05100 RECOVERY ROOM	0.438025	0	198,333	0	0
53.00 05300 ANESTHESIOLOGY	0.047926	0	245,446	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.193370	0	5,093,671	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.167581	0	4,588,483	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.277616	0	1,483,330	0	0
66.00 06600 PHYSICAL THERAPY	0.662036	0	324,542	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.494769	0	93,762	0	0
68.00 06800 SPEECH PATHOLOGY	0.744484	0	9,690	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.714276	0	86,037	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.250211	0	2,770,934	5,381	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.388782	0	1,409,116	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.766641	0	322,811	0	0
93.00 04040 ROCHESTER MEDICAL	2.168186	0	130,878	1,218	0
93.01 04951 ROCHESTER ORTHO	4.110515	0	60,783	0	0
93.02 04950 ROCHESTER SURGICAL	5.489628	0	40,451	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	18,186,212	6,599	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	18,186,212	6,599	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 4/13/2016 9:17 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	313,651	0		50.00
51.00 05100 RECOVERY ROOM	86,875	0		51.00
53.00 05300 ANESTHESIOLOGY	11,763	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	984,963	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	768,943	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	411,796	0		65.00
66.00 06600 PHYSICAL THERAPY	214,858	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	46,391	0		67.00
68.00 06800 SPEECH PATHOLOGY	7,214	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	61,454	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	693,318	1,346		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	547,839	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	247,480	0		92.00
93.00 04040 ROCHESTER MEDICAL	283,768	2,641		93.00
93.01 04951 ROCHESTER ORTHO	249,849	0		93.01
93.02 04950 ROCHESTER SURGICAL	222,061	0		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	5,152,223	3,987		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,152,223	3,987		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 4/13/2016 9:17 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.236193	0	0	0	0
51.00 05100 RECOVERY ROOM	0.438025	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.047926	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.193370	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.167581	0	0	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.277616	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.662036	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.494769	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.744484	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.714276	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.250211	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.388782	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.766641	0	0	0	0
93.00 04040 ROCHESTER MEDICAL	2.168186	0	0	0	0
93.01 04951 ROCHESTER ORTHO	4.110515	0	0	0	0
93.02 04950 ROCHESTER SURGICAL	5.489628	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)			0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 4/13/2016 9:17 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 ROCHESTER MEDICAL	0	0		93.00
93.01 04951 ROCHESTER ORTHO	0	0		93.01
93.02 04950 ROCHESTER SURGICAL	0	0		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 4/13/2016 9:17 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,885	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,738	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,839	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		99	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		48	7.00
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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,279	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		99	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,429,508	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		6,199	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		117,199	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,312,309	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	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	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)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,312,309	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,121.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,434,028	39.00
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)		1,434,028	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 4/13/2016 9:17 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,040,507	538	1,934.03	242	468,035		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,783,115		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,685,178		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					111,000		64.00
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)					111,000		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						899	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,121.21		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,007,968		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 4/13/2016 9:17 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	534,612	5,312,309	0.100636	1,007,968	101,438	90.00
91.00	Nursing School cost	0	5,312,309	0.000000	1,007,968	0	91.00
92.00	Allied health cost	0	5,312,309	0.000000	1,007,968	0	92.00
93.00	All other Medical Education	0	5,312,309	0.000000	1,007,968	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 4/13/2016 9:17 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,885	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,738	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,839	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		99	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		48	7.00
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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		113	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,429,508	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		6,199	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		117,199	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,312,309	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	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	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)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,312,309	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,121.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		126,697	39.00
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)		126,697	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Date/Time Prepared: 4/13/2016 9:17 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,040,507	538	1,934.03	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					104,515		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					231,212		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
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 (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						899	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,121.21	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,007,968	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 4/13/2016 9:17 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	534,612	5,312,309	0.100636	1,007,968	101,438	90.00
91.00	Nursing School cost	0	5,312,309	0.000000	1,007,968	0	91.00
92.00	Allied health cost	0	5,312,309	0.000000	1,007,968	0	92.00
93.00	All other Medical Education	0	5,312,309	0.000000	1,007,968	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 4/13/2016 9:17 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,497,581	30.00
31.00	03100	INTENSIVE CARE UNIT		553,658	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.236193	950,963	50.00
51.00	05100	RECOVERY ROOM	0.438025	79,302	51.00
53.00	05300	ANESTHESIOLOGY	0.047926	64,932	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193370	497,943	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.167581	988,910	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.277616	1,192,492	65.00
66.00	06600	PHYSICAL THERAPY	0.662036	132,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.494769	38,433	67.00
68.00	06800	SPEECH PATHOLOGY	0.744484	17,143	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.714276	638,001	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250211	1,408,346	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.388782	371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.766641	0	92.00
93.00	04040	ROCHESTER MEDICAL	2.168186	0	93.00
93.01	04951	ROCHESTER ORTHO	4.110515	0	93.01
93.02	04950	ROCHESTER SURGICAL	5.489628	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		6,009,119	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		6,009,119	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2015	Worksheet D-3	
		Component CCN: 15Z313	To 12/31/2015	Date/Time Prepared: 4/13/2016 9:17 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.236193	2,892	683
51.00	05100	RECOVERY ROOM	0.438025	6	3
53.00	05300	ANESTHESIOLOGY	0.047926	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193370	5,153	996
57.00	05700	CT SCAN	0.000000	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0
60.00	06000	LABORATORY	0.167581	11,593	1,943
60.01	06001	BLOOD LABORATORY	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	0.277616	24,646	6,842
66.00	06600	PHYSICAL THERAPY	0.662036	21,536	14,258
67.00	06700	OCCUPATIONAL THERAPY	0.494769	12,041	5,958
68.00	06800	SPEECH PATHOLOGY	0.744484	3,212	2,391
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.714276	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250211	82,579	20,662
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0
91.00	09100	EMERGENCY	0.388782	4	2
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.766641	0	0
93.00	04040	ROCHESTER MEDICAL	2.168186	0	0
93.01	04951	ROCHESTER ORTHO	4.110515	0	0
93.02	04950	ROCHESTER SURGICAL	5.489628	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0
200.00		Total (sum of lines 50-94 and 96-98)		163,662	53,738
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	
202.00		Net Charges (line 200 minus line 201)		163,662	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 4/13/2016 9:17 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		148,116		30.00
31.00	03100 INTENSIVE CARE UNIT		23,495		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.236193	101,033	23,863	50.00
51.00	05100 RECOVERY ROOM	0.438025	15,394	6,743	51.00
53.00	05300 ANESTHESIOLOGY	0.047926	7,319	351	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193370	19,072	3,688	54.00
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	0.167581	69,035	11,569	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.277616	47,437	13,169	65.00
66.00	06600 PHYSICAL THERAPY	0.662036	3,495	2,314	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.494769	1,047	518	67.00
68.00	06800 SPEECH PATHOLOGY	0.744484	75	56	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.714276	25,293	18,066	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250211	82,366	20,609	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.388782	9,180	3,569	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.766641	0	0	92.00
93.00	04040 ROCHESTER MEDICAL	2.168186	0	0	93.00
93.01	04951 ROCHESTER ORTHO	4.110515	0	0	93.01
93.02	04950 ROCHESTER SURGICAL	5.489628	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		380,746	104,515	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		380,746		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 4/13/2016 9:17 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			5,156,210 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,156,210 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,207,772 21.00
22.00	Interns and residents (see instructions)			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, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			56,005 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,744,177 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,407,590 27.00
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)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,407,590 30.00
31.00	Primary payer payments			1,365 31.00
32.00	Subtotal (line 30 minus line 31)			2,406,225 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			508,389 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			330,453 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			508,389 36.00
37.00	Subtotal (see instructions)			2,736,678 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
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)			2,736,678 40.00
40.01	Sequestration adjustment (see instructions)			54,734 40.01
41.00	Interim payments			2,657,500 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			24,444 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,308,143		2,657,500	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	07/13/2015	64,400		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		64,400		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,372,543		2,657,500	4.00	
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)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		24,444	6.01	
6.02	SETTLEMENT TO PROGRAM		119,629		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,252,914		2,681,944	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151313  
Component CCN: 15Z313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/13/2016 9:17 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		173,012		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		173,012		0	4.00
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)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		10,110		0	6.02
7.00	Total Medicare program liability (see instructions)		162,902		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 4/13/2016 9:17 am
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1,080 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,521 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			607 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4,377 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			103,267,234 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			1,862,464 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 4/13/2016 9:17 am
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	112,110	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	54,275	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	99	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	166,385	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	166,385	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	166,385	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	158	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	166,227	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	166,227	0	19.00
19.01	Sequestration adjustment (see instructions)	3,325	0	19.01
20.00	Interim payments	173,012	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-10,110	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 4/13/2016 9:17 am
		Title VIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			3,685,178 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			3,685,178 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,722,030 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3,722,030 19.00
20.00	Deductibles (exclude professional component)			409,324 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			3,312,706 22.00
23.00	Coinsurance			5,670 23.00
24.00	Subtotal (line 22 minus line 23)			3,307,036 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			18,867 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			12,264 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,867 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,319,300 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			3,319,300 30.00
30.01	Sequestration adjustment (see instructions)			66,386 30.01
31.00	Interim payments			3,372,543 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			-119,629 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 4/13/2016 9:17 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		231,212		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		231,212	0	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)		231,212	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		171,611		8.00
9.00	Ancillary service charges		380,746	0	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)		552,357	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		552,357	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		321,145	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		231,212	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		231,212	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		231,212	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		231,212	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		231,212	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		231,212	0	40.00
41.00	Interim payments		217,761	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		13,451	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G

Date/Time Prepared:  
4/13/2016 9:17 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	3,721,917	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,978,752	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,225,923	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	4,412,266	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,338,858	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	489,647	0	0	0	13.00
14.00	Accumulated depreciation	-392,366	0	0	0	14.00
15.00	Buildings	26,811,816	0	0	0	15.00
16.00	Accumulated depreciation	-10,924,351	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,423,409	0	0	0	23.00
24.00	Accumulated depreciation	-6,588,706	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,415,665	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,457,886	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,457,886	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,212,409	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	5,676,819	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,398,255	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,148,599	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,223,673	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,564,272	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,564,272	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,787,945	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	14,424,464				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,424,464	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,212,409	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-1

Date/Time Prepared:  
4/13/2016 9:17 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		13,657,436		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		767,028			2.00
3.00	Total (sum of line 1 and line 2)		14,424,464		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		14,424,464		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,424,464		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
4/13/2016 9:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	6,077,700		6,077,700	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,077,700		6,077,700	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,590,248		1,590,248	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,590,248		1,590,248	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,667,948		7,667,948	17.00
18.00	Ancillary services	16,032,297	71,274,929	87,307,226	18.00
19.00	Outpatient services	1,916,291	17,062,198	18,978,489	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICES	0	8,626,715	8,626,715	27.00
27.01	MISC REVENUE	0	20,500	20,500	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	25,616,536	96,984,342	122,600,878	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,992,677		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		50,992,677		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151313

Period:  
From 01/01/2015  
To 12/31/2015

Worksheet G-3

Date/Time Prepared:  
4/13/2016 9:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	122,600,878	1.00
2.00	Less contractual allowances and discounts on patients' accounts	71,890,371	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,710,507	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,992,677	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-282,170	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	860,396	24.00
24.01	INVESTMENT INCOME	9,288	24.01
24.02	OTHER NONOPERATING INCOME	163,197	24.02
25.00	Total other income (sum of lines 6-24)	1,032,881	25.00
26.00	Total (line 5 plus line 25)	750,711	26.00
27.00	GAIN ON DISPOSITION OF ASSETS	-16,317	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-16,317	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	767,028	29.00