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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 1:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 1:25 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WOODLAWN HOSPITAL (15-1313) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	101,614	-37,676	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	18,348	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	119,962	-37,676	0	0	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: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 1:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1400 EAST 9TH STREET	PO Box:			1.00
2.00	City: ROCHESTER	State: IN	Zip Code: 46975-	County: FULTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		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	O	O	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	15Z313	99915		10/23/2001	N	O	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
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	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 §412.106(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	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	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	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	N	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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 1:24 pm

		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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
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)(i) or (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)(i) or (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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
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	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	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (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)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 1:24 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						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)						61.06

		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. Enter in column 4, the 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. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
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
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
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 through 67. (see instructions)	N	63.00

		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 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.				
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	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 1:24 pm

		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	
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

		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	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is 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
	Inpatient Rehabilitation Facility PPS				
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

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		1.00	2.00	3.00	
76.00	If line 75 is 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	
	Long Term Care Hospital PPS		
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
	TEFRA Providers		
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.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
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	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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a 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. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 1:24 pm

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	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 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	132,289	26,028	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
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
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
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 1:24 pm

		1.00	2.00	
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:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		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.			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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		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	166.00

		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)	93,550	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)	01/01/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 1:24 pm

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 1:24 pm

		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		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? 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	03/02/2018	Y	03/02/2018	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 1:24 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed 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
	Interest Expense					
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
	Purchased Services					
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
	Provider-Based Physicians					
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	
	Home Office Costs					
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		
	Cost Report Preparer Contact Information					
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.	ROBERT		BRANDENBURG		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000		BBRANDENBURG@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 1:24 pm

		3.00		
	Cost Report Preparer Contact Information			
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.	PARTNER		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: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 1:24 pm

	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	70,224.00	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	70,224.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	12,096.00	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	82,320.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 1:24 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,128	53	2,926			1.00
2.00	HMO and other (see instructions)	619	133				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	95	0	95			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	34			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,223	53	3,055			7.00
8.00	INTENSIVE CARE UNIT	230	0	504			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		165	371			13.00
14.00	Total (see instructions)	1,453	218	3,930	0.00	394.63	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	394.63	27.00
28.00	Observation Bed Days		0	625			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 1:24 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	348	17	978	1.00
2.00	HMO and other (see instructions)			160	48		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	348	17	978	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/29/2018 1:24 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.324064	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,940,850	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 and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,157,291	5.00
6.00	Medicaid charges	19,634,183	6.00
7.00	Medicaid cost (line 1 times line 6)	6,362,732	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)	1,264,591	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,264,591	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,167,516	0	1,167,516	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	378,350	0	378,350	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	378,350	0	378,350	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,315,244	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	739,603	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,137,851	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,177,393	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,103,863	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,482,213	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,746,804	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,509,589	2,509,589	-176,615	2,332,974	1.00
1.02	00102	AKRON BUILDING		46,954	46,954	0	46,954	1.02
1.03	00103	ARGOS BUILDING		86,815	86,815	0	86,815	1.03
1.04	00101	CLAYS BUILDING		15,035	15,035	176,615	191,650	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	207,317	3,934,004	4,141,321	0	4,141,321	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,965,778	4,137,516	7,103,294	75,853	7,179,147	5.00
7.00	00700	OPERATION OF PLANT	343,642	1,152,225	1,495,867	0	1,495,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,398	129,820	145,218	0	145,218	8.00
9.00	00900	HOUSEKEEPING	378,355	176,202	554,557	0	554,557	9.00
10.00	01000	DIETARY	377,599	311,479	689,078	-453,138	235,940	10.00
11.00	01100	CAFETERIA	0	0	0	453,138	453,138	11.00
13.00	01300	NURSING ADMINISTRATION	115,925	49,918	165,843	0	165,843	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	314,998	4,355,988	4,670,986	0	4,670,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	570,639	425,791	996,430	0	996,430	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,232,992	863,471	3,096,463	-537,305	2,559,158	30.00
31.00	03100	INTENSIVE CARE UNIT	451,629	137,780	589,409	0	589,409	31.00
43.00	04300	NURSERY	0	0	0	271,073	271,073	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	807,502	1,308,523	2,116,025	0	2,116,025	50.00
51.00	05100	RECOVERY ROOM	348,587	156,872	505,459	0	505,459	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	266,232	266,232	52.00
53.00	05300	ANESTHESIOLOGY	0	914,111	914,111	0	914,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,736,276	1,278,330	3,014,606	0	3,014,606	54.00
60.00	06000	LABORATORY	854,552	1,531,461	2,386,013	0	2,386,013	60.00
65.00	06500	RESPIRATORY THERAPY	1,027,446	301,784	1,329,230	0	1,329,230	65.00
66.00	06600	PHYSICAL THERAPY	678,546	181,499	860,045	0	860,045	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,775	40,194	221,969	0	221,969	67.00
68.00	06800	SPEECH PATHOLOGY	70,487	26,433	96,920	0	96,920	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	991,675	991,675	0	991,675	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,017,718	2,656,383	3,674,101	0	3,674,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	2,393,460	1,256,778	3,650,238	0	3,650,238	93.00
93.01	04951	ROCHESTER ORTHO	2,213,063	314,216	2,527,279	0	2,527,279	93.01
93.02	04950	ROCHESTER SURGICAL	2,096,764	230,973	2,327,737	0	2,327,737	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,400,448	29,521,819	50,922,267	75,853	50,998,120	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,746,689	1,580,514	5,327,203	0	5,327,203	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	69,664	260,930	330,594	-75,853	254,741	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	25,216,801	31,363,263	56,580,064	0	56,580,064	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-31,123	2,301,851		1.00
1.02	00102	AKRON BUILDING	0	46,954		1.02
1.03	00103	ARGOS BUILDING	0	86,815		1.03
1.04	00101	CLAYS BUILDING	0	191,650		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-87,065	4,054,256		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,697,459	5,481,688		5.00
7.00	00700	OPERATION OF PLANT	0	1,495,867		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	145,218		8.00
9.00	00900	HOUSEKEEPING	0	554,557		9.00
10.00	01000	DIETARY	-20,673	215,267		10.00
11.00	01100	CAFETERIA	-124,291	328,847		11.00
13.00	01300	NURSING ADMINISTRATION	0	165,843		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-321,792	4,349,194		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-31,781	964,649		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,559,158		30.00
31.00	03100	INTENSIVE CARE UNIT	0	589,409		31.00
43.00	04300	NURSERY	0	271,073		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,116,025		50.00
51.00	05100	RECOVERY ROOM	0	505,459		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	266,232		52.00
53.00	05300	ANESTHESIOLOGY	-850,828	63,283		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-263,244	2,751,362		54.00
60.00	06000	LABORATORY	-24,996	2,361,017		60.00
65.00	06500	RESPIRATORY THERAPY	-10,944	1,318,286		65.00
66.00	06600	PHYSICAL THERAPY	-16,968	843,077		66.00
67.00	06700	OCCUPATIONAL THERAPY	-50,473	171,496		67.00
68.00	06800	SPEECH PATHOLOGY	-4,172	92,748		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	991,675		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,804,510	1,869,591		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
93.00	04040	ROCHESTER MEDICAL	-2,089,728	1,560,510		93.00
93.01	04951	ROCHESTER ORTHO	-1,939,685	587,594		93.01
93.02	04950	ROCHESTER SURGICAL	-2,010,991	316,746		93.02
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,380,723	39,617,397		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	5,327,203		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	ADVERTISING	0	254,741		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,380,723	45,199,341		200.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 1:24 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	248,309	204,829		1.00
	0		248,309	204,829		
	B - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	15,984	59,869		1.00
	0		15,984	59,869		
	C - DEPRECIATION					
1.00	CLAYS BUILDING	1.04	0	176,615		1.00
	0		0	176,615		
	D - NURSERY					
1.00	NURSERY	43.00	198,506	72,567		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	194,961	71,271		2.00
	0		393,467	143,838		
500.00	Grand Total: Increases		657,760	585,151		500.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 1:24 pm

	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	248,309	204,829	0		1.00
	0		248,309	204,829			
	B - ADVERTISING						
1.00	ADVERTISING	194.00	15,984	59,869	0		1.00
	0		15,984	59,869			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	176,615	9		1.00
	0		0	176,615			
	D - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	393,467	143,838	0		1.00
2.00		0.00	0	0	0		2.00
	0		393,467	143,838			
500.00	Grand Total: Decreases		657,760	585,151			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I Date/Time Prepared: 5/29/2018 1:24 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	596,216	0	0	0	0	1.00
2.00	Land Improvements	510,775	0	0	0	0	2.00
3.00	Buildings and Fixtures	26,831,601	310,335	0	310,335	0	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	9,823,668	0	0	0	114,416	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,762,260	310,335	0	310,335	114,416	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,762,260	310,335	0	310,335	114,416	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	596,216	0	1.00
2.00	Land Improvements	510,775	0	2.00
3.00	Buildings and Fixtures	27,141,936	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,709,252	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,958,179	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,958,179	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2018 1:24 pm

	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	CAP REL COSTS-BLDG & FIXT	1,324,905	0	594,540	565,719	24,425	1.00
1.02	AKRON BUILDING	28,466	0	0	0	10,404	1.02
1.03	ARGOS BUILDING	51,792	0	0	0	14,970	1.03
1.04	CLAYS BUILDING	0	0	0	0	15,035	1.04
3.00	Total (sum of lines 1-2)	1,405,163	0	594,540	565,719	64,834	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	CAP REL COSTS-BLDG & FIXT	0	2,509,589		1.00
1.02	AKRON BUILDING	8,084	46,954		1.02
1.03	ARGOS BUILDING	20,053	86,815		1.03
1.04	CLAYS BUILDING	0	15,035		1.04
3.00	Total (sum of lines 1-2)	28,137	2,658,393		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2018 1:24 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,048,143	0	36,048,143	0.949680	0	1.00
1.02	AKRON BUILDING	670,438	0	670,438	0.017663	0	1.02
1.03	ARGOS BUILDING	1,239,598	0	1,239,598	0.032657	0	1.03
1.04	CLAYS BUILDING	0	0	0	0.000000	0	1.04
3.00	Total (sum of lines 1-2)	37,958,179	0	37,958,179	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,124,577	0	1.00
1.02	AKRON BUILDING	0	0	0	28,466	0	1.02
1.03	ARGOS BUILDING	0	0	0	51,792	0	1.03
1.04	CLAYS BUILDING	0	0	0	176,615	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,381,450	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	CAP REL COSTS-BLDG & FIXT	587,130	565,719	24,425	0	2,301,851	1.00
1.02	AKRON BUILDING	0	0	10,404	8,084	46,954	1.02
1.03	ARGOS BUILDING	0	0	14,970	20,053	86,815	1.03
1.04	CLAYS BUILDING	0	0	15,035	0	191,650	1.04
3.00	Total (sum of lines 1-2)	587,130	565,719	64,834	28,137	2,627,270	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 1:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-7,410	CAP REL COSTS-BLDG & FIXT	1.00	11	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	-8,991,902			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	B	-124,261	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical 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	B	-31,781	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-30	CAFETERIA	11.00	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 - CAP REL COSTS-BLDG & FIXT		0	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 1:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	B	-23,713	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	HOME MEAL PROGRAM	B	-11,569	DIETARY	10.00	0	33.00
34.00	DIETARY SPEC EVENTS	B	-9,104	DIETARY	10.00	0	34.00
35.00	SUPPLY SALES	B	-99	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PT - OTHER REVENUE	B	-1,968	PHYSICAL THERAPY	66.00	0	36.00
37.00	OCC THER OTH REV	B	-50,473	OCCUPATIONAL THERAPY	67.00	11	37.00
38.00	EDUCATION OTHER REVENUE	B	-1,402	ADMINISTRATIVE & GENERAL	5.00	11	38.00
39.00	RESPIRATORY OTHER REV	B	-3,024	RESPIRATORY THERAPY	65.00	0	39.00
40.00	ATHLETIC TRAINING -OTH REV	B	-15,000	PHYSICAL THERAPY	66.00	0	40.00
41.00	DRUG SALES	B	-321,792	PHARMACY	15.00	0	41.00
42.00	CHAPLAIN - OTHER REVENUE	B	-900	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	PURCHASE DISCOUNTS	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	SPEECH THERAPY OTHER REVENUE	B	-4,172	SPEECH PATHOLOGY	68.00	0	44.00
45.00	PHYSICIAN RECRUITMENT-HR	A	-87,065	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
45.01	PHYS RECRUITMENT - OTH EXP	A	-13,666	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	HOSPITAL ASSESSMENT FEE	A	-1,520,101	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	IHA LOBBYING DUES	A	-864	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	AHA LOBBYING DUES	A	-4,071	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	PART B BILLING OFFSET	A	-53,058	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	LTC EXPENSES	A	-103,278	ADMINISTRATIVE & GENERAL	5.00	0	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,380,723				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: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2018 1:24 pm

	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	53.00	ANESTHESIOLOGY	850,828	850,828	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	263,244	263,244	0	0	0	2.00
3.00	60.00	LABORATORY	24,996	24,996	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	7,920	7,920	0	0	0	4.00
5.00	91.00	EMERGENCY	2,246,707	1,804,510	432,410	0	0	5.00
6.00	93.00	ROCHESTER MEDICAL	2,089,728	2,089,728	0	0	0	6.00
7.00	93.01	ROCHESTER ORTHO	1,939,685	1,939,685	0	0	0	7.00
8.00	93.02	ROCHESTER SURGICAL	2,010,991	2,010,991	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			9,434,099	8,991,902	432,410		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	53.00	ANESTHESIOLOGY	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	53.00	ANESTHESIOLOGY	0	0	0	850,828		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	263,244		2.00
3.00	60.00	LABORATORY	0	0	0	24,996		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	7,920		4.00
5.00	91.00	EMERGENCY	0	0	0	1,804,510		5.00
6.00	93.00	ROCHESTER MEDICAL	0	0	0	2,089,728		6.00
7.00	93.01	ROCHESTER ORTHO	0	0	0	1,939,685		7.00
8.00	93.02	ROCHESTER SURGICAL	0	0	0	2,010,991		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	8,991,902		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,301,851	2,301,851				1.00
1.02	00102	AKRON BUILDING	46,954	0	46,954			1.02
1.03	00103	ARGOS BUILDING	86,815	0	0	86,815		1.03
1.04	00101	CLAYS BUILDING	191,650	0	0	0	191,650	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,054,256	9,337	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,481,688	261,131	5,366	6,945	150	5.00
7.00	00700	OPERATION OF PLANT	1,495,867	218,509	3,220	7,918	81,379	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	145,218	9,419	0	0	0	8.00
9.00	00900	HOUSEKEEPING	554,557	24,666	0	0	413	9.00
10.00	01000	DIETARY	215,267	36,958	0	0	1,399	10.00
11.00	01100	CAFETERIA	328,847	71,762	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	165,843	59,306	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,349,194	22,717	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	964,649	21,321	0	0	5,174	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,559,158	344,592	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	589,409	49,394	0	0	0	31.00
43.00	04300	NURSERY	271,073	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,116,025	172,069	0	0	0	50.00
51.00	05100	RECOVERY ROOM	505,459	107,284	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	266,232	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	63,283	2,873	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,751,362	250,480	0	0	0	54.00
60.00	06000	LABORATORY	2,361,017	54,791	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,318,286	90,211	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	843,077	72,645	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	171,496	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	92,748	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	991,675	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,869,591	134,618	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	1,560,510	232,217	0	0	35,079	93.00
93.01	04951	ROCHESTER ORTHO	587,594	0	0	0	54,206	93.01
93.02	04950	ROCHESTER SURGICAL	316,746	49,764	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,617,397	2,296,064	8,586	14,863	177,800	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,327,203	0	38,368	71,952	13,850	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	254,741	5,787	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,199,341	2,301,851	46,954	86,815	191,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	4,063,593					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	617,293	6,372,573	6,372,573			5.00
7.00	00700	OPERATION OF PLANT	71,142	1,878,035	308,238	2,186,273		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,188	157,825	25,904	11,344	195,073	8.00
9.00	00900	HOUSEKEEPING	78,328	657,964	107,990	29,708	41,008	9.00
10.00	01000	DIETARY	26,766	280,390	46,020	44,512	5,426	10.00
11.00	01100	CAFETERIA	51,406	452,015	74,188	86,430	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,999	249,148	40,892	71,427	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	65,212	4,437,123	728,256	32,525	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118,135	1,109,279	182,064	25,679	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	380,824	3,284,574	539,091	415,022	49,715	30.00
31.00	03100	INTENSIVE CARE UNIT	93,498	732,301	120,191	59,490	7,571	31.00
43.00	04300	NURSERY	41,095	312,168	51,236	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	167,171	2,455,265	402,978	204,248	17,791	50.00
51.00	05100	RECOVERY ROOM	72,166	684,909	112,413	129,212	7,066	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,361	306,593	50,320	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	66,156	10,858	3,460	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	359,449	3,361,291	551,682	301,701	22,081	54.00
60.00	06000	LABORATORY	176,912	2,592,720	425,538	65,990	0	60.00
65.00	06500	RESPIRATORY THERAPY	212,705	1,621,202	266,085	108,649	11,356	65.00
66.00	06600	PHYSICAL THERAPY	140,475	1,056,197	173,352	87,492	1,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,632	209,128	34,324	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,592	107,340	17,617	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	991,675	162,762	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	210,691	2,214,900	363,527	162,133	31,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0				92.00
93.00	04040	ROCHESTER MEDICAL	179,421	2,007,227	329,442	281,706	0	93.00
93.01	04951	ROCHESTER ORTHO	65,058	706,858	116,015	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	29,316	395,826	64,966	58,575	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,276,835	38,700,682	5,305,949	2,179,303	195,073	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	775,645	6,227,018	1,022,040	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	11,113	271,641	44,584	6,970	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 through 201)	4,063,593	45,199,341	6,372,573	2,186,273	195,073	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	836,670					9.00
10.00	01000	DIETARY	2,914	379,262				10.00
11.00	01100	CAFETERIA	9,222	0	621,855			11.00
13.00	01300	NURSING ADMINISTRATION	1,371	0	2,314	365,152		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	9,462	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,931	0	41,568	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	204,758	330,624	96,630	234,686	0	30.00
31.00	03100	INTENSIVE CARE UNIT	43,767	48,638	20,691	42,982	0	31.00
43.00	04300	NURSERY	0	0	8,263	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	89,859	0	55,432	0	0	50.00
51.00	05100	RECOVERY ROOM	72,957	0	14,836	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	8,101	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,464	0	70,522	0	0	54.00
60.00	06000	LABORATORY	29,279	0	42,355	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,879	0	47,100	0	0	65.00
66.00	06600	PHYSICAL THERAPY	16,491	0	24,626	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,416	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,967	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	14,095	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	78,682	0	42,124	87,484	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	109,915	0	64,134	0	0	93.00
93.01	04951	ROCHESTER ORTHO	26,742	0	0	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	9,257	0	18,539	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	835,950	379,262	578,713	365,152	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	40,781	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	720	0	2,361	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 through 201)	836,670	379,262	621,855	365,152	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 1:24 pm

		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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	5,207,366					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,364,521				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	73,735	5,228,835	0	5,228,835	30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,059	1,089,690	0	1,089,690	31.00
43.00	04300	NURSERY	0	2,910	374,577	0	374,577	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	152,956	3,378,529	0	3,378,529	50.00
51.00	05100	RECOVERY ROOM	0	20,939	1,042,332	0	1,042,332	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,843	367,857	0	367,857	52.00
53.00	05300	ANESTHESIOLOGY	0	23,518	103,992	0	103,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	294,058	4,699,799	0	4,699,799	54.00
60.00	06000	LABORATORY	0	249,237	3,405,119	0	3,405,119	60.00
65.00	06500	RESPIRATORY THERAPY	0	81,090	2,162,361	0	2,162,361	65.00
66.00	06600	PHYSICAL THERAPY	0	23,360	1,382,654	0	1,382,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,184	258,052	0	258,052	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,923	130,847	0	130,847	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	46,829	1,201,266	0	1,201,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,207,366	255,212	5,476,673	0	5,476,673	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	80,807	3,061,580	0	3,061,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
93.00	04040	ROCHESTER MEDICAL	0	21,244	2,813,668	0	2,813,668	93.00
93.01	04951	ROCHESTER ORTHO	0	4,598	854,213	0	854,213	93.01
93.02	04950	ROCHESTER SURGICAL	0	4,019	551,182	0	551,182	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,207,366	1,364,521	37,583,226	0	37,583,226	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	7,289,839	0	7,289,839	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	326,276	0	326,276	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,207,366	1,364,521	45,199,341	0	45,199,341	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	9,337	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	261,131	5,366	6,945	150	5.00
7.00	00700	OPERATION OF PLANT	0	218,509	3,220	7,918	81,379	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,419	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	24,666	0	0	413	9.00
10.00	01000	DIETARY	0	36,958	0	0	1,399	10.00
11.00	01100	CAFETERIA	0	71,762	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	59,306	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	22,717	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,321	0	0	5,174	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	344,592	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	49,394	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	172,069	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	107,284	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,873	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	250,480	0	0	0	54.00
60.00	06000	LABORATORY	0	54,791	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	90,211	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	72,645	0	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 PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	134,618	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	0	232,217	0	0	35,079	93.00
93.01	04951	ROCHESTER ORTHO	0	0	0	0	54,206	93.01
93.02	04950	ROCHESTER SURGICAL	0	49,764	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,296,064	8,586	14,863	177,800	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	38,368	71,952	13,850	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	5,787	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,301,851	46,954	86,815	191,650	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	9,337	9,337				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	273,592	1,419	275,011			5.00
7.00	00700	OPERATION OF PLANT	311,026	164	13,302	324,492		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,419	7	1,118	1,684	12,228	8.00
9.00	00900	HOUSEKEEPING	25,079	180	4,660	4,409	2,571	9.00
10.00	01000	DIETARY	38,357	62	1,986	6,607	340	10.00
11.00	01100	CAFETERIA	71,762	118	3,202	12,828	0	11.00
13.00	01300	NURSING ADMINISTRATION	59,306	55	1,765	10,601	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	22,717	150	31,428	4,828	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,495	272	7,857	3,811	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	344,592	876	23,265	61,599	3,116	30.00
31.00	03100	INTENSIVE CARE UNIT	49,394	215	5,187	8,830	475	31.00
43.00	04300	NURSERY	0	94	2,211	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	172,069	384	17,391	30,315	1,115	50.00
51.00	05100	RECOVERY ROOM	107,284	166	4,851	19,178	443	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	93	2,172	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,873	0	469	514	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	250,480	826	23,808	44,779	1,384	54.00
60.00	06000	LABORATORY	54,791	407	18,364	9,794	0	60.00
65.00	06500	RESPIRATORY THERAPY	90,211	489	11,483	16,126	712	65.00
66.00	06600	PHYSICAL THERAPY	72,645	323	7,481	12,986	71	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87	1,481	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	34	760	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,024	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	134,618	484	15,688	24,064	2,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0					92.00
93.00	04040	ROCHESTER MEDICAL	267,296	413	14,217	41,811	0	93.00
93.01	04951	ROCHESTER ORTHO	54,206	150	5,007	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	49,764	67	2,804	8,694	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,497,313	7,535	228,981	323,458	12,228	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	124,170	1,776	44,106	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	5,787	26	1,924	1,034	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 through 201)	2,627,270	9,337	275,011	324,492	12,228	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	36,899					9.00
10.00	01000	DIETARY	129	47,481				10.00
11.00	01100	CAFETERIA	407	0	88,317			11.00
13.00	01300	NURSING ADMINISTRATION	60	0	329	72,116		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	417	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	262	0	5,904	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,032	41,392	13,725	46,349	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,930	6,089	2,939	8,489	0	31.00
43.00	04300	NURSERY	0	0	1,173	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,963	0	7,873	0	0	50.00
51.00	05100	RECOVERY ROOM	3,218	0	2,107	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,150	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,342	0	10,016	0	0	54.00
60.00	06000	LABORATORY	1,291	0	6,015	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,185	0	6,689	0	0	65.00
66.00	06600	PHYSICAL THERAPY	727	0	3,497	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	769	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	279	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,002	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,470	0	5,982	17,278	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	4,847	0	9,108	0	0	93.00
93.01	04951	ROCHESTER ORTHO	1,179	0	0	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	408	0	2,633	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,867	47,481	82,190	72,116	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	5,792	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	32	0	335	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 through 201)	36,899	47,481	88,317	72,116	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 1:24 pm

		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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	59,540					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,601				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,413	546,359	0	546,359	30.00
31.00	03100	INTENSIVE CARE UNIT	0	460	84,008	0	84,008	31.00
43.00	04300	NURSERY	0	95	3,573	0	3,573	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,005	238,115	0	238,115	50.00
51.00	05100	RECOVERY ROOM	0	685	137,932	0	137,932	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	93	3,508	0	3,508	52.00
53.00	05300	ANESTHESIOLOGY	0	770	4,626	0	4,626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,575	345,210	0	345,210	54.00
60.00	06000	LABORATORY	0	8,155	98,817	0	98,817	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,653	129,548	0	129,548	65.00
66.00	06600	PHYSICAL THERAPY	0	764	98,494	0	98,494	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	301	2,638	0	2,638	67.00
68.00	06800	SPEECH PATHOLOGY	0	128	1,201	0	1,201	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,532	8,556	0	8,556	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,540	8,351	69,893	0	69,893	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	2,644	206,229	0	206,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
93.00	04040	ROCHESTER MEDICAL	0	695	338,387	0	338,387	93.00
93.01	04951	ROCHESTER ORTHO	0	150	60,692	0	60,692	93.01
93.02	04950	ROCHESTER SURGICAL	0	132	64,502	0	64,502	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,540	44,601	2,442,288	0	2,442,288	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	175,844	0	175,844	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	9,138	0	9,138	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	59,540	44,601	2,627,270	0	2,627,270	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (ASSIGNED TIME)	
			1.00	1.02	1.03	1.04	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,170					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	455	0	0	0	19,628,730	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,725	400	600	16	2,981,762	5.00
7.00	00700	OPERATION OF PLANT	10,648	240	684	8,667	343,642	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	459	0	0	0	15,398	8.00
9.00	00900	HOUSEKEEPING	1,202	0	0	44	378,355	9.00
10.00	01000	DIETARY	1,801	0	0	149	129,290	10.00
11.00	01100	CAFETERIA	3,497	0	0	0	248,309	11.00
13.00	01300	NURSING ADMINISTRATION	2,890	0	0	0	115,925	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,107	0	0	0	314,998	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,039	0	0	551	570,639	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,792	0	0	0	1,839,525	30.00
31.00	03100	INTENSIVE CARE UNIT	2,407	0	0	0	451,629	31.00
43.00	04300	NURSERY	0	0	0	0	198,506	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,385	0	0	0	807,502	50.00
51.00	05100	RECOVERY ROOM	5,228	0	0	0	348,587	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	194,961	52.00
53.00	05300	ANESTHESIOLOGY	140	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,206	0	0	0	1,736,276	54.00
60.00	06000	LABORATORY	2,670	0	0	0	854,552	60.00
65.00	06500	RESPIRATORY THERAPY	4,396	0	0	0	1,027,446	65.00
66.00	06600	PHYSICAL THERAPY	3,540	0	0	0	678,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	181,775	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	70,487	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,560	0	0	0	1,017,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	11,316	0	0	3,736	866,670	93.00
93.01	04951	ROCHESTER ORTHO	0	0	0	5,773	314,255	93.01
93.02	04950	ROCHESTER SURGICAL	2,425	0	0	0	141,608	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,888	640	1,284	18,936	15,828,361	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,860	6,216	1,475	3,746,689	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	282	0	0	0	53,680	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)	2,301,851	46,954	86,815	191,650	4,063,593	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.521093	13.415429	11.575333	9.389545	0.207023	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,337	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000476	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	-6,372,573	38,826,768				5.00
7.00	00700	OPERATION OF PLANT	0	1,878,035	88,458			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	157,825	459	1,546		8.00
9.00	00900	HOUSEKEEPING	0	657,964	1,202	325	122,020	9.00
10.00	01000	DIETARY	0	280,390	1,801	43	425	10.00
11.00	01100	CAFETERIA	0	452,015	3,497	0	1,345	11.00
13.00	01300	NURSING ADMINISTRATION	0	249,148	2,890	0	200	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	4,437,123	1,316	0	1,380	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,109,279	1,039	0	865	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,284,574	16,792	394	29,862	30.00
31.00	03100	INTENSIVE CARE UNIT	0	732,301	2,407	60	6,383	31.00
43.00	04300	NURSERY	0	312,168	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,455,265	8,264	141	13,105	50.00
51.00	05100	RECOVERY ROOM	0	684,909	5,228	56	10,640	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	306,593	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	66,156	140	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,361,291	12,207	175	14,360	54.00
60.00	06000	LABORATORY	0	2,592,720	2,670	0	4,270	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,621,202	4,396	90	3,920	65.00
66.00	06600	PHYSICAL THERAPY	0	1,056,197	3,540	9	2,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,128	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	107,340	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	991,675	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	2,214,900	6,560	253	11,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	0	2,007,227	11,398	0	16,030	93.00
93.01	04951	ROCHESTER ORTHO	0	706,858	0	0	3,900	93.01
93.02	04950	ROCHESTER SURGICAL	0	395,826	2,370	0	1,350	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,372,573	32,328,109	88,176	1,546	121,915	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,227,018	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	271,641	282	0	105	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)		6,372,573	2,186,273	195,073	836,670	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.164128	24.715379	126.179172	6.856827	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		275,011	324,492	12,228	36,899	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007083	3.668317	7.909444	0.302401	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	3,930					10.00
11.00	01100	CAFETERIA	0	26,868				11.00
13.00	01300	NURSING ADMINISTRATION	0	100	157,999			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,723,307		14.00
15.00	01500	PHARMACY	0	0	0	2,904	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,796	0	4,548	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,426	4,175	101,547	118,659	0	30.00
31.00	03100	INTENSIVE CARE UNIT	504	894	18,598	27,986	0	31.00
43.00	04300	NURSERY	0	357	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,395	0	776,083	0	50.00
51.00	05100	RECOVERY ROOM	0	641	0	74,898	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	350	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,997	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,047	0	80,237	0	54.00
60.00	06000	LABORATORY	0	1,830	0	13,952	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,035	0	59,410	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,064	0	9,248	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	234	0	312	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	85	0	2	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	609	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,820	37,854	82,672	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04040	ROCHESTER MEDICAL	0	2,771	0	118,191	0	93.00
93.01	04951	ROCHESTER ORTHO	0	0	0	31,627	0	93.01
93.02	04950	ROCHESTER SURGICAL	0	801	0	44,474	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,930	25,004	157,999	1,465,200	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,762	0	257,091	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	102	0	1,016	0	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)	379,262	621,855	365,152	0	5,207,366	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	96.504326	23.144819	2.311103	0.000000	52,073.660000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,481	88,317	72,116	0	59,540	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.081679	3.287070	0.456433	0.000000	595.400000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 1:24 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	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	115,974,692		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,266,803		30.00
31.00	03100	INTENSIVE CARE UNIT	1,194,896		31.00
43.00	04300	NURSERY	247,307		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	12,999,844		50.00
51.00	05100	RECOVERY ROOM	1,779,595		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	241,598		52.00
53.00	05300	ANESTHESIOLOGY	1,998,845		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,995,202		54.00
60.00	06000	LABORATORY	21,182,846		60.00
65.00	06500	RESPIRATORY THERAPY	6,891,891		65.00
66.00	06600	PHYSICAL THERAPY	1,985,418		66.00
67.00	06700	OCCUPATIONAL THERAPY	780,585		67.00
68.00	06800	SPEECH PATHOLOGY	333,402		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,980,067		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,690,641		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	6,867,834		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
93.00	04040	ROCHESTER MEDICAL	1,805,509		93.00
93.01	04951	ROCHESTER ORTHO	390,822		93.01
93.02	04950	ROCHESTER SURGICAL	341,587		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,974,692		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	ADVERTISING	0		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)	1,364,521		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011766		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,601		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000385		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 1:24 pm

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	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,228,835		5,228,835	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,089,690		1,089,690	0	0	31.00
43.00	04300	NURSERY	374,577		374,577	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,378,529		3,378,529	0	0	50.00
51.00	05100	RECOVERY ROOM	1,042,332		1,042,332	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	367,857		367,857	0	0	52.00
53.00	05300	ANESTHESIOLOGY	103,992		103,992	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699,799		4,699,799	0	0	54.00
60.00	06000	LABORATORY	3,405,119		3,405,119	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,162,361	0	2,162,361	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,382,654	0	1,382,654	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,052	0	258,052	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	130,847	0	130,847	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,201,266		1,201,266	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,476,673		5,476,673	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,061,580		3,061,580	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	895,531		895,531		0	92.00
93.00	04040	ROCHESTER MEDICAL	2,813,668		2,813,668	0	0	93.00
93.01	04951	ROCHESTER ORTHO	854,213		854,213	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	551,182		551,182	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,478,757	0	38,478,757	0	0	200.00
201.00		Less Observation Beds	895,531		895,531		0	201.00
202.00		Total (see instructions)	37,583,226	0	37,583,226	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,452,074		3,452,074			30.00
31.00	03100	INTENSIVE CARE UNIT	1,194,896		1,194,896			31.00
43.00	04300	NURSERY	247,307		247,307			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,682,632	10,317,212	12,999,844	0.259890	0.000000	50.00
51.00	05100	RECOVERY ROOM	443,182	1,336,413	1,779,595	0.585713	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,318	64,280	241,598	1.522600	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	327,100	1,671,745	1,998,845	0.052026	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,317,691	23,677,511	24,995,202	0.188028	0.000000	54.00
60.00	06000	LABORATORY	2,771,023	18,411,823	21,182,846	0.160749	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,337,346	4,554,545	6,891,891	0.313754	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	330,211	1,655,207	1,985,418	0.696404	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,271	665,314	780,585	0.330588	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,827	319,575	333,402	0.392460	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,150,517	829,550	3,980,067	0.301821	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,876,085	17,814,556	21,690,641	0.252490	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	321,345	6,546,489	6,867,834	0.445785	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	172,390	2,642,339	2,814,729	0.318159	0.000000	92.00
93.00	04040	ROCHESTER MEDICAL	0	1,805,509	1,805,509	1.558379	0.000000	93.00
93.01	04951	ROCHESTER ORTHO	0	390,822	390,822	2.185683	0.000000	93.01
93.02	04950	ROCHESTER SURGICAL	0	341,587	341,587	1.613592	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,930,215	93,044,477	115,974,692			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,930,215	93,044,477	115,974,692			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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 PAT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 1:24 pm

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	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,228,835		5,228,835	0	5,228,835	30.00
31.00	03100	INTENSIVE CARE UNIT	1,089,690		1,089,690	0	1,089,690	31.00
43.00	04300	NURSERY	374,577		374,577	0	374,577	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,378,529		3,378,529	0	3,378,529	50.00
51.00	05100	RECOVERY ROOM	1,042,332		1,042,332	0	1,042,332	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	367,857		367,857	0	367,857	52.00
53.00	05300	ANESTHESIOLOGY	103,992		103,992	0	103,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699,799		4,699,799	0	4,699,799	54.00
60.00	06000	LABORATORY	3,405,119		3,405,119	0	3,405,119	60.00
65.00	06500	RESPIRATORY THERAPY	2,162,361	0	2,162,361	0	2,162,361	65.00
66.00	06600	PHYSICAL THERAPY	1,382,654	0	1,382,654	0	1,382,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,052	0	258,052	0	258,052	67.00
68.00	06800	SPEECH PATHOLOGY	130,847	0	130,847	0	130,847	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,201,266		1,201,266	0	1,201,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,476,673		5,476,673	0	5,476,673	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,061,580		3,061,580	0	3,061,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	895,531		895,531		895,531	92.00
93.00	04040	ROCHESTER MEDICAL	2,813,668		2,813,668	0	2,813,668	93.00
93.01	04951	ROCHESTER ORTHO	854,213		854,213	0	854,213	93.01
93.02	04950	ROCHESTER SURGICAL	551,182		551,182	0	551,182	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,478,757	0	38,478,757	0	38,478,757	200.00
201.00		Less Observation Beds	895,531		895,531		895,531	201.00
202.00		Total (see instructions)	37,583,226	0	37,583,226	0	37,583,226	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 1:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,452,074		3,452,074			30.00
31.00	03100	INTENSIVE CARE UNIT	1,194,896		1,194,896			31.00
43.00	04300	NURSERY	247,307		247,307			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,682,632	10,317,212	12,999,844	0.259890	0.000000	50.00
51.00	05100	RECOVERY ROOM	443,182	1,336,413	1,779,595	0.585713	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,318	64,280	241,598	1.522600	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	327,100	1,671,745	1,998,845	0.052026	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,317,691	23,677,511	24,995,202	0.188028	0.000000	54.00
60.00	06000	LABORATORY	2,771,023	18,411,823	21,182,846	0.160749	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,337,346	4,554,545	6,891,891	0.313754	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	330,211	1,655,207	1,985,418	0.696404	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,271	665,314	780,585	0.330588	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,827	319,575	333,402	0.392460	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,150,517	829,550	3,980,067	0.301821	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,876,085	17,814,556	21,690,641	0.252490	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	321,345	6,546,489	6,867,834	0.445785	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	172,390	2,642,339	2,814,729	0.318159	0.000000	92.00
93.00	04040	ROCHESTER MEDICAL	0	1,805,509	1,805,509	1.558379	0.000000	93.00
93.01	04951	ROCHESTER ORTHO	0	390,822	390,822	2.185683	0.000000	93.01
93.02	04950	ROCHESTER SURGICAL	0	341,587	341,587	1.613592	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,930,215	93,044,477	115,974,692			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,930,215	93,044,477	115,974,692			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 1:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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 PAT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	238,115	12,999,844	0.018317	1,201,680	22,011	50.00
51.00	05100	RECOVERY ROOM	137,932	1,779,595	0.077508	113,849	8,824	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,508	241,598	0.014520	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,626	1,998,845	0.002314	83,910	194	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,210	24,995,202	0.013811	542,877	7,498	54.00
60.00	06000	LABORATORY	98,817	21,182,846	0.004665	1,096,123	5,113	60.00
65.00	06500	RESPIRATORY THERAPY	129,548	6,891,891	0.018797	1,117,220	21,000	65.00
66.00	06600	PHYSICAL THERAPY	98,494	1,985,418	0.049609	131,290	6,513	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,638	780,585	0.003380	38,652	131	67.00
68.00	06800	SPEECH PATHOLOGY	1,201	333,402	0.003602	8,124	29	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,556	3,980,067	0.002150	620,583	1,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,893	21,690,641	0.003222	1,384,090	4,460	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	206,229	6,867,834	0.030028	16,482	495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	93,574	2,814,729	0.033244	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	338,387	1,805,509	0.187419	0	0	93.00
93.01	04951	ROCHESTER ORTHO	60,692	390,822	0.155293	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	64,502	341,587	0.188830	0	0	93.02
200.00		Total (lines 50 through 199)	1,901,922	111,080,415		6,354,880	77,602	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	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 PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		0		0	92.00
93.00	04040	ROCHESTER MEDICAL	0	0	0	0	0	93.00
93.01	04951	ROCHESTER ORTHO	0	0	0	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	0	0	0	0	0	93.02
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	12,999,844	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,779,595	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	241,598	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,998,845	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,995,202	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	21,182,846	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,891,891	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,985,418	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	780,585	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	333,402	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,980,067	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,690,641	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	6,867,834	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,814,729	0.000000	92.00
93.00	04040	ROCHESTER MEDICAL	0	0	0	1,805,509	0.000000	93.00
93.01	04951	ROCHESTER ORTHO	0	0	0	390,822	0.000000	93.01
93.02	04950	ROCHESTER SURGICAL	0	0	0	341,587	0.000000	93.02
200.00		Total (lines 50 through 199)	0	0	0	111,080,415		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,201,680	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	113,849	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	83,910	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	542,877	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,096,123	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,117,220	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	131,290	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	38,652	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	8,124	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	620,583	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,384,090	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	16,482	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	0.000000	0	0	0	0	93.00
93.01	04951	ROCHESTER ORTHO	0.000000	0	0	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	0.000000	0	0	0	0	93.02
200.00		Total (lines 50 through 199)		6,354,880	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.259890	0	1,800,895	0	0	50.00
51.00	05100	RECOVERY ROOM	0.585713	0	179,460	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522600	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.052026	0	342,716	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188028	0	6,798,912	0	0	54.00
60.00	06000	LABORATORY	0.160749	0	5,174,434	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.313754	0	1,415,078	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.696404	0	478,994	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330588	0	152,629	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.392460	0	18,661	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301821	0	89,745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252490	0	8,425,093	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.445785	0	1,480,673	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.318159	0	512,473	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	1.558379	0	205,946	0	0	93.00
93.01	04951	ROCHESTER ORTHO	2.185683	0	61,883	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	1.613592	0	43,809	0	0	93.02
200.00		Subtotal (see instructions)		0	27,181,401	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	27,181,401	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	468,035	0		50.00
51.00	05100	RECOVERY ROOM	105,112	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	17,830	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,278,386	0		54.00
60.00	06000	LABORATORY	831,785	0		60.00
65.00	06500	RESPIRATORY THERAPY	443,986	0		65.00
66.00	06600	PHYSICAL THERAPY	333,573	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	50,457	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,324	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,087	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,127,252	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	660,062	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	163,048	0		92.00
93.00	04040	ROCHESTER MEDICAL	320,942	0		93.00
93.01	04951	ROCHESTER ORTHO	135,257	0		93.01
93.02	04950	ROCHESTER SURGICAL	70,690	0		93.02
200.00		Subtotal (see instructions)	7,040,826	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,040,826	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.259890	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.585713	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522600	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.052026	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188028	0	0	0	0	54.00
60.00	06000	LABORATORY	0.160749	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.313754	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.696404	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330588	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.392460	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301821	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252490	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.445785	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.318159	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	1.558379	0	0	0	0	93.00
93.01	04951	ROCHESTER ORTHO	2.185683	0	0	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	1.613592	0	0	0	0	93.02
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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 PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 1:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.259890	0	85,350	0	0	50.00
51.00	05100	RECOVERY ROOM	0.585713	0	11,056	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522600	0	532	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.052026	0	13,830	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188028	0	195,873	0	0	54.00
60.00	06000	LABORATORY	0.160749	0	152,313	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.313754	0	37,678	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.696404	0	13,693	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330588	0	5,504	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.392460	0	2,644	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301821	0	6,862	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252490	0	147,372	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.445785	0	54,156	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.318159	0	21,859	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	1.558379	0	14,936	0	0	93.00
93.01	04951	ROCHESTER ORTHO	2.185683	0	3,233	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	1.613592	0	2,826	0	0	93.02
200.00		Subtotal (see instructions)		0	769,717	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	769,717	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 1:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	22,182	0		50.00
51.00	05100	RECOVERY ROOM	6,476	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	810	0		52.00
53.00	05300	ANESTHESIOLOGY	720	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,830	0		54.00
60.00	06000	LABORATORY	24,484	0		60.00
65.00	06500	RESPIRATORY THERAPY	11,822	0		65.00
66.00	06600	PHYSICAL THERAPY	9,536	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,820	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,038	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,071	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,210	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	24,142	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	6,955	0		92.00
93.00	04040	ROCHESTER MEDICAL	23,276	0		93.00
93.01	04951	ROCHESTER ORTHO	7,066	0		93.01
93.02	04950	ROCHESTER SURGICAL	4,560	0		93.02
200.00		Subtotal (see instructions)	220,998	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	220,998	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,680	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,551	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)	2,926	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	95	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	34	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)	1,128	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)	95	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
	SWING BED ADJUSTMENT		
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	137.32	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)	5,228,835	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)	4,669	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)	140,790	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,088,045	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
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)	5,088,045	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,432.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,616,255	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)	1,616,255	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | 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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,089,690	504	2,162.08	230	497,278	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)	1,663,681	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,777,214	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)	136,121	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)	136,121	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)	625	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,432.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	895,531	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	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	546,359	5,228,835	0.104490	895,531	93,574	90.00
91.00	Nursing School cost	0	5,228,835	0.000000	895,531	0	91.00
92.00	Allied health cost	0	5,228,835	0.000000	895,531	0	92.00
93.00	All other Medical Education	0	5,228,835	0.000000	895,531	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 1:24 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,680	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,551	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)	2,926	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	95	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	34	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)	53	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)	371	15.00
16.00	Nursery days (title V or XIX only)	165	16.00
	SWING BED ADJUSTMENT		
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	137.32	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)	5,228,835	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)	4,669	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)	140,790	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,088,045	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
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)	5,088,045	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,432.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	75,941	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)	75,941	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 1:24 pm

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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	374,577	371	1,009.64	165	166,591	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,089,690	504	2,162.08	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)	39,772	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	282,304	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)	625	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,432.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	895,531	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 1:24 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	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	546,359	5,228,835	0.104490	895,531	93,574	90.00
91.00	Nursing School cost	0	5,228,835	0.000000	895,531	0	91.00
92.00	Allied health cost	0	5,228,835	0.000000	895,531	0	92.00
93.00	All other Medical Education	0	5,228,835	0.000000	895,531	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 1:24 pm

Title XVIII | Hospital | 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,321,992		30.00
31.00	03100	INTENSIVE CARE UNIT		563,332		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.259890	1,201,680	312,305	50.00
51.00	05100	RECOVERY ROOM	0.585713	113,849	66,683	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522600	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.052026	83,910	4,366	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188028	542,877	102,076	54.00
60.00	06000	LABORATORY	0.160749	1,096,123	176,201	60.00
65.00	06500	RESPIRATORY THERAPY	0.313754	1,117,220	350,532	65.00
66.00	06600	PHYSICAL THERAPY	0.696404	131,290	91,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330588	38,652	12,778	67.00
68.00	06800	SPEECH PATHOLOGY	0.392460	8,124	3,188	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301821	620,583	187,305	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252490	1,384,090	349,469	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.445785	16,482	7,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.318159	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	1.558379	0	0	93.00
93.01	04951	ROCHESTER ORTHO	2.185683	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	1.613592	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,354,880	1,663,681	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)		6,354,880		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 1:24 pm

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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.259890	441	115	50.00
51.00	05100	RECOVERY ROOM	0.585713	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522600	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.052026	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188028	4,329	814	54.00
60.00	06000	LABORATORY	0.160749	12,605	2,026	60.00
65.00	06500	RESPIRATORY THERAPY	0.313754	27,091	8,500	65.00
66.00	06600	PHYSICAL THERAPY	0.696404	29,271	20,384	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330588	13,622	4,503	67.00
68.00	06800	SPEECH PATHOLOGY	0.392460	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301821	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252490	22,096	5,579	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.445785	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.318159	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	1.558379	0	0	93.00
93.01	04951	ROCHESTER ORTHO	2.185683	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	1.613592	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		109,455	41,921	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)		109,455		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 1:24 pm

Title XIX | Hospital | 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		27,073		30.00
31.00	03100	INTENSIVE CARE UNIT		9,371		31.00
43.00	04300	NURSERY		1,940		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.259890	21,039	5,468	50.00
51.00	05100	RECOVERY ROOM	0.585713	3,476	2,036	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522600	1,391	2,118	52.00
53.00	05300	ANESTHESIOLOGY	0.052026	2,565	133	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188028	10,334	1,943	54.00
60.00	06000	LABORATORY	0.160749	21,732	3,493	60.00
65.00	06500	RESPIRATORY THERAPY	0.313754	18,331	5,751	65.00
66.00	06600	PHYSICAL THERAPY	0.696404	2,590	1,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.330588	904	299	67.00
68.00	06800	SPEECH PATHOLOGY	0.392460	108	42	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301821	24,708	7,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252490	30,398	7,675	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.445785	2,520	1,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.318159	1,352	430	92.00
93.00	04040	ROCHESTER MEDICAL	1.558379	0	0	93.00
93.01	04951	ROCHESTER ORTHO	2.185683	0	0	93.01
93.02	04950	ROCHESTER SURGICAL	1.613592	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		141,448	39,772	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)		141,448		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 1:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,040,826	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, 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)	7,040,826	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
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
	Customary charges		
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 chargebasis 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 (see instructions)	7,111,234	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, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	78,372	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,391,108	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)	2,641,754	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)	2,641,754	30.00
31.00	Primary payer payments	452	31.00
32.00	Subtotal (line 30 minus line 31)	2,641,302	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,084,553	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	704,959	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	930,987	36.00
37.00	Subtotal (see instructions)	3,346,261	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,346,261	40.00
40.01	Sequestration adjustment (see instructions)	66,925	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,317,012	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-37,676	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
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: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2018 1:24 pm

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		3,026,936		3,317,012	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	08/02/2017	273,900		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)		273,900		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)		3,300,836		3,317,012	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		101,614		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		37,676	6.02
7.00	Total Medicare program liability (see instructions)		3,402,450		3,279,336	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: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 1:24 pm

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		152,557		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)		152,557		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		18,348		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		170,905		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: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 1:24 pm
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1313 Component CCN: 15-Z313	Period: From 01/01/2017 To 12/31/2017	Worksheet E-2 Date/Time Prepared: 5/29/2018 1:24 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	137,482	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)	42,340	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	95	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)	179,822	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	179,822	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)	179,822	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,429	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)	174,393	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
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)	174,393	0	19.00
19.01	Sequestration adjustment (see instructions)	3,488	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	152,557	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)	18,348	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Prepared: 5/29/2018 1:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,777,214	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)	3,777,214	4.00
5.00	Primary payer payments	9,458	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,805,528	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
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
	Customary charges		
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
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
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)	3,805,528	19.00
20.00	Deductibles (exclude professional component)	368,284	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,437,244	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,437,244	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,298	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	34,644	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,052	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,471,888	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	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,471,888	30.00
30.01	Sequestration adjustment (see instructions)	69,438	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,300,836	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, 30.02, 31, and 32)	101,614	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/29/2018 1:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	9,497,295	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	21,462,617	0	0	0	4.00
5.00	Other receivable	277,058	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,582,410	0	0	0	6.00
7.00	Inventory	1,061,773	0	0	0	7.00
8.00	Prepaid expenses	302,303	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-578,238	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,440,398	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	510,775	0	0	0	13.00
14.00	Accumulated depreciation	-327,666	0	0	0	14.00
15.00	Buildings	27,141,936	0	0	0	15.00
16.00	Accumulated depreciation	-12,270,708	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	9,709,252	0	0	0	23.00
24.00	Accumulated depreciation	-7,203,100	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)	18,156,705	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,663,466	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	981,682	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,645,148	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,242,251	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,729,472	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	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				42.00
43.00	Due to other funds	4,092,428	0	0	0	43.00
44.00	Other current liabilities	2,705,256	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,527,156	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,072,403	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,072,403	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,599,559	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16,642,692				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)	16,642,692	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,242,251	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/29/2018 1:24 pm

		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		14,646,582		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,996,110				2.00
3.00	Total (sum of line 1 and line 2)		16,642,692		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		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)		16,642,692		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,642,692		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: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2018 1:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,511,397		6,511,397	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				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)	6,511,397		6,511,397	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,917,817		1,917,817	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)	1,917,817		1,917,817	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,429,214		8,429,214	17.00
18.00	Ancillary services	17,008,326	81,405,136	98,413,462	18.00
19.00	Outpatient services	2,173,845	17,505,338	19,679,183	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				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	0	6,979,840	6,979,840	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	27,611,385	105,890,314	133,501,699	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,580,064		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)		56,580,064		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/29/2018 1:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	133,501,699	1.00
2.00	Less contractual allowances and discounts on patients' accounts	79,485,502	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,016,197	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,580,064	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,563,867	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	40,000	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	20	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	144,934	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	99	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	30	21.00
22.00	Rental of hospital space	16,091	22.00
23.00	Governmental appropriations	0	23.00
24.00	IDENTIFIED ON TRIAL BALANCE	4,625,117	24.00
25.00	Total other income (sum of lines 6-24)	4,826,291	25.00
26.00	Total (line 5 plus line 25)	2,262,424	26.00
27.00	MISC INCOME AUDIT ADJUSTMENT	266,314	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	266,314	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,996,110	29.00