

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/20/2014 4:24 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/20/2014	Time: 4:24 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WOODLAWN HOSPITAL (151313) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 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.

Encryption Information

ECR: Date: 5/20/2014 Time: 4:24 pm
fcBt: 1Hpf6Tn857sbhPPLXlFqFhpU0
GzSme0oikbzIukofriawtSX5wgOmPk
3Fzy0EgDS60rBDFQ
PI: Date: 5/20/2014 Time: 4:24 pm
MjDPfQmJqayF0Mr9d6yb5Jw1POU:20
ODugH0Gwc7w02.0R0dhsK5g.wID2hv
ScyD0ozSjD0pN8bs

(Signed)

John Alley
Officer or Administrator of Provider(s)
CEO

Title
5-30-14
Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	258,119	127,440	167,714	3,344	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	8,582	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	266,701	127,440	167,714	3,344	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/20/2014 9:29 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 46975-		County: FULTON		1.00
1.00	Street: 1400 EAST 9TH STREET	2.00		3.00		4.00		5.00		2.00
2.00	City: ROCHESTER	3.00		4.00		5.00		6.00		7.00

	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	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WOODLAWN HOSPITAL SWINGBED	152313	99915		10/23/2001	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			

20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	8		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01
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	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

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		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 in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V	XVII	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 Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	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 Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
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 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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
76.00	If line 75 yes: Column 1: Did the facility have a 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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		
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		
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.					
				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		
93.00	Does this facility operate an ICF/MR 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

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		V	XIX			
		1.00	2.00			
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	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: 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 would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	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	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 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 hospital providers) based on the definition in CMS 15-1, §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:	322,904	56,390	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	
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

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		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N			145.00		
				1.00	2.00		
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, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00		
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 1.00	Part B 2.00	Title V 3.00	Title XIX 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		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
161.10	CORF		N	N	N		
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00		
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §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)	223,972			168.00		
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 1.00		Ending 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)	01/01/2013		12/31/2013			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/20/2014 9:29 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
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	Type	Date
			1.00	2.00	3.00
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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been 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	Legal Oper.	
			1.00	2.00	
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	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/04/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/20/2014 9:29 am
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
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.	KYLE		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM	43.00

		Part B	
		Date	
		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)	02/04/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
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.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	96,408.00	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	96,408.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	14,784.00	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	111,192.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,365	181	4,062			1.00
2.00 HMO and other (see instructions)	913	421				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	58	0	59			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	75			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,423	181	4,196			7.00
8.00 INTENSIVE CARE UNIT	277	0	616			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	1,700	181	4,812	0.00	365.37	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	365.37	27.00
28.00 Observation Bed Days		0	734			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	409	62	1,227	1.00	
2.00 HMO and other (see instructions)			224			2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						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	409	62	1,227	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00	
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY	0.00					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
25.10 CMHC - CORF	0.00					25.10	
26.00 RURAL HEALTH CLINIC	0.00					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25	
27.00 Total (sum of lines 14-26)	0.00					27.00	
28.00 Observation Bed Days						28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01	
33.00 LTCH non-covered days						33.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/20/2014 9:29 am
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			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)		0.373814	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,665,099	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		965,680	5.00	
6.00	Medicaid charges		9,457,570	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,535,372	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)		904,593	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		904,593	19.00	
			1.00		
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,883,267	0	2,883,267	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,077,806	0	1,077,806	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,077,806	0	1,077,806	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		5,101,913	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		426,470	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		4,675,443	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,747,746	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,825,552	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,730,145	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 151313		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Date/Time Prepared: 5/20/2014 9:29 am							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT		2,529,562	2,529,562	-113,359	2,416,203	1.00
1.02 00102	AKRON BUILDING		30,054	30,054	19,989	50,043	1.02
1.03 00103	ARGOS BUILDING		52,687	52,687	32,288	84,975	1.03
1.04 00101	CLAYS BUILDING		0	0	135,333	135,333	1.04
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	177,763	3,025,494	3,203,257	0	3,203,257	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,281,301	3,890,966	6,172,267	246,803	6,419,070	5.00
7.00 00700	OPERATION OF PLANT	297,810	1,129,612	1,427,422	64,406	1,491,828	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	28,122	77,858	105,980	0	105,980	8.00
9.00 00900	HOUSEKEEPING	310,415	112,869	423,284	0	423,284	9.00
10.00 01000	DIETARY	344,188	292,419	636,607	-506,949	129,658	10.00
11.00 01100	CAFETERIA	0	0	0	506,949	506,949	11.00
13.00 01300	NURSING ADMINISTRATION	146,813	39,545	186,358	0	186,358	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500	PHARMACY	282,381	2,965,289	3,247,670	-1,224	3,246,446	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	507,362	241,159	748,521	0	748,521	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	2,320,354	876,222	3,196,576	0	3,196,576	30.00
31.00 03100	INTENSIVE CARE UNIT	473,348	151,377	624,725	0	624,725	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	840,087	1,580,402	2,420,489	0	2,420,489	50.00
51.00 05100	RECOVERY ROOM	335,320	106,076	441,396	0	441,396	51.00
53.00 05300	ANESTHESIOLOGY	0	791,105	791,105	0	791,105	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,431,082	1,344,868	2,775,950	0	2,775,950	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	717,111	1,276,872	1,993,983	0	1,993,983	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	1,024,328	293,788	1,318,116	0	1,318,116	65.00
66.00 06600	PHYSICAL THERAPY	683,442	172,287	855,729	0	855,729	66.00
67.00 06700	OCCUPATIONAL THERAPY	181,019	34,221	215,240	0	215,240	67.00
68.00 06800	SPEECH PATHOLOGY	72,546	15,557	88,103	0	88,103	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	923,013	923,013	0	923,013	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	880,432	1,872,016	2,752,448	0	2,752,448	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	ROCHESTER MEDICAL	1,884,363	757,766	2,642,129	-74,862	2,567,267	93.00
93.01 04041	ROCHESTER ORTHO	2,170,318	389,487	2,559,805	-41,445	2,518,360	93.01
93.02 04042	ROCHESTER SURGICAL	1,401,971	136,556	1,538,527	-14,322	1,524,205	93.02
OTHER REIMBURSABLE COST CENTERS							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,791,876	25,109,127	43,901,003	253,607	44,154,610	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,232,279	1,092,967	3,325,246	-144,492	3,180,754	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ADVERTISING	86,774	378,290	465,064	-109,115	355,949	194.00
200.00	TOTAL (SUM OF LINES 118-199)	21,110,929	26,580,384	47,691,313	0	47,691,313	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-77,492	2,338,711	1.00
1.02	00102	AKRON BUILDING	0	50,043	1.02
1.03	00103	ARGOS BUILDING	0	84,975	1.03
1.04	00101	CLAYS BUILDING	0	135,333	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,203,257	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,844,097	4,574,973	5.00
7.00	00700	OPERATION OF PLANT	0	1,491,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,980	8.00
9.00	00900	HOUSEKEEPING	0	423,284	9.00
10.00	01000	DIETARY	-34,036	95,622	10.00
11.00	01100	CAFETERIA	-126,549	380,400	11.00
13.00	01300	NURSING ADMINISTRATION	0	186,358	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-492,348	2,754,098	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	748,521	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,196,576	30.00
31.00	03100	INTENSIVE CARE UNIT	0	624,725	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-19,961	2,400,528	50.00
51.00	05100	RECOVERY ROOM	0	441,396	51.00
53.00	05300	ANESTHESIOLOGY	-742,568	48,537	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-162,832	2,613,118	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,993,983	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-8,500	1,309,616	65.00
66.00	06600	PHYSICAL THERAPY	-60,714	795,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	215,240	67.00
68.00	06800	SPEECH PATHOLOGY	0	88,103	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	923,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-1,051,953	1,700,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	ROCHESTER MEDICAL	-1,216,486	1,350,781	93.00
93.01	04041	ROCHESTER ORTHO	-1,935,075	583,285	93.01
93.02	04042	ROCHESTER SURGICAL	-1,316,081	208,124	93.02
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,088,692	35,065,918	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,180,754	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	ADVERTISING	0	355,949	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-9,088,692	38,602,621	200.00

RECLASSIFICATIONS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-6

Date/Time Prepared:
5/20/2014 9:29 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - CAFETERIA						
1.00	CAFETERIA	11.00	214,530	292,419	1.00	
	TOTALS		214,530	292,419		
B - PHYSICIANS CLINIC						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	9,754	1.00	
2.00	AKRON BUILDING	1.02	0	19,989	2.00	
3.00	ARGOS BUILDING	1.03	0	32,288	3.00	
4.00	CLAYS BUILDING	1.04	0	12,220	4.00	
5.00	ADMINISTRATIVE & GENERAL	5.00	0	137,688	5.00	
	TOTALS		0	211,939		
C - ADVERTISING						
1.00	ADMINISTRATIVE & GENERAL	5.00	20,359	88,756	1.00	
	TOTALS		20,359	88,756		
D - DEPRECIATION						
1.00	CLAYS BUILDING	1.04	0	123,113	1.00	
	TOTALS		0	123,113		
E - UTILITY RECLASS						
1.00	OPERATION OF PLANT	7.00	0	64,406	1.00	
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,038	2.00	
	TOTALS		0	69,444		
500.00	Grand Total: Increases		234,889	785,671	500.00	

RECLASSIFICATIONS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-6

Date/Time Prepared:
5/20/2014 9:29 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	214,530	292,419	0	1.00
	TOTALS		214,530	292,419		
B - PHYSICIANS CLINIC						
1.00	PHARMACY	15.00	0	1,224	12	1.00
2.00	ROCHESTER MEDICAL	93.00	0	33,860	12	2.00
3.00	ROCHESTER ORTHO	93.01	0	13,003	12	3.00
4.00	ROCHESTER SURGICAL	93.02	0	14,322	12	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	149,530	0	5.00
	TOTALS		0	211,939		
C - ADVERTISING						
1.00	ADVERTISING	194.00	20,359	88,756	0	1.00
	TOTALS		20,359	88,756		
D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	123,113	9	1.00
	TOTALS		0	123,113		
E - UTILITY RECLASS						
1.00	ROCHESTER MEDICAL	93.00	0	41,002	0	1.00
2.00	ROCHESTER ORTHO	93.01	0	28,442	0	2.00
	TOTALS		0	69,444		
500.00	Grand Total: Decreases		234,889	785,671		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-7
Part I
Date/Time Prepared:
5/20/2014 9:29 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	596,216	0	0	0	0	1.00
2.00	Land Improvements	472,590	18,613	0	18,613	1,476	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	24,777,661	1,436,820	0	1,436,820	39,212	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,043,840	581,173	0	581,173	306,492	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,890,307	2,036,606	0	2,036,606	347,180	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,890,307	2,036,606	0	2,036,606	347,180	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	489,727	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	26,175,269	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,318,521	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	35,579,733	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	35,579,733	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-7
Part II
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,377,260	0	733,294	406,973	12,035	1.00
1.02	AKRON BUILDING	30,054	0	0	0	0	1.02
1.03	ARGOS BUILDING	52,687	0	0	0	0	1.03
1.04	CLAYS BUILDING	0	0	0	0	0	1.04
3.00	Total (sum of lines 1-2)	1,460,001	0	733,294	406,973	12,035	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,529,562				1.00
1.02	AKRON BUILDING	0	30,054				1.02
1.03	ARGOS BUILDING	0	52,687				1.03
1.04	CLAYS BUILDING	0	0				1.04
3.00	Total (sum of lines 1-2)	0	2,612,303				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-7
Part III
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	33,989,887	0	33,989,887	0.955316	0	1.00
1.02	AKRON BUILDING	585,638	0	585,638	0.016460	0	1.02
1.03	ARGOS BUILDING	1,004,208	0	1,004,208	0.028224	0	1.03
1.04	CLAYS BUILDING	0	0	0	0.000000	0	1.04
3.00	Total (sum of lines 1-2)	35,579,733	0	35,579,733	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,204,909	0	1.00
1.02	AKRON BUILDING	0	0	0	30,054	0	1.02
1.03	ARGOS BUILDING	0	0	0	52,687	0	1.03
1.04	CLAYS BUILDING	0	0	0	123,113	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,410,763	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	705,040	416,727	12,035	0	2,338,711	1.00
1.02	AKRON BUILDING	0	19,989	0	0	50,043	1.02
1.03	ARGOS BUILDING	0	32,288	0	0	84,975	1.03
1.04	CLAYS BUILDING	0	12,220	0	0	135,333	1.04
3.00	Total (sum of lines 1-2)	705,040	481,224	12,035	0	2,609,062	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-8

Date/Time Prepared:
5/20/2014 9:29 am

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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02 Investment income - AKRON BUILDING (chapter 2)			0	AKRON BUILDING	1.02	0	1.02
1.03 Investment income - ARGOS BUILDING (chapter 2)			0	ARGOS BUILDING	1.03	0	1.03
1.04 Investment income - CLAYS BUILDING (chapter 2)			0	CLAYS BUILDING	1.04	0	1.04
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,702,388					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				12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02 Depreciation - AKRON BUILDING			0	AKRON BUILDING	1.02	0	26.02
26.03 Depreciation - ARGOS BUILDING			0	ARGOS BUILDING	1.03	0	26.03
26.04 Depreciation - CLAYS BUILDING			0	CLAYS BUILDING	1.04	0	26.04
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00

Provider CCN: 151313

Period:
 From 01/01/2013
 To 12/31/2013

Worksheet A-8

Date/Time Prepared:
 5/20/2014 9:29 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-49,238		NEW CAP REL COSTS-BLDG & FIXT	1.00	9 32.00
33.00 PHYSICIAN RECRUITMENT	A	-44,113		ADMINISTRATIVE & GENERAL	5.00	0 33.00
34.00 PHYSICIAN RECRUITMENT	A	-105,501		ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00 ANESTHESIA OFFSET	A	-742,568		ANESTHESIOLOGY	53.00	0 35.00
36.00 HAF EXPENSE	A	-1,585,002		ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 DELINQUENT A/R -INT INCME	B	-324		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 37.00
38.00 PATIENT ACCOUNTS - INT INCOME	B	-11,325		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 38.00
39.00 OTHER INCOME -INT INCME	B	-16,270		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 39.00
40.00 SAVINGS -INT INCME	B	-335		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 40.00
41.00 EDUCATION OTHER REVENUE	B	-2,312		ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 CLERICAL FEES -HIM	B	-23,240		ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00 CHAPLAIN - OTHER REVENUE	B	-1,500		ADMINISTRATIVE & GENERAL	5.00	0 43.00
44.00 CHECKING -INT INCME	B	-2,009		ADMINISTRATIVE & GENERAL	5.00	0 44.00
45.00 PATIENT SUPPLY/SUPPLEMENT CHAR	B	-435		DIETARY	10.00	0 45.00
45.01 HOME MEAL PROGRAM	B	-21,084		DIETARY	10.00	0 45.01
45.02 DIETARY SPEC EVENTS	B	-12,517		DIETARY	10.00	0 45.02
45.03 HOUSEKEEPING VENDING-OTH REV	B	-52		CAFETERIA	11.00	0 45.03
45.04 CAFETERIA SALES	B	-126,497		CAFETERIA	11.00	0 45.04
45.05 SUPPLY SALES	B	-14,363		ADMINISTRATIVE & GENERAL	5.00	0 45.05
45.06 DRUG SALES	B	-492,348		PHARMACY	15.00	0 45.06
45.07 RESPIRATORY OTHER REV	B	-8,500		RESPIRATORY THERAPY	65.00	0 45.07
45.08 PT - OTHER REVENUE	B	-6,986		PHYSICAL THERAPY	66.00	0 45.08
45.09 OCC THER OTH REV	B	-38,728		PHYSICAL THERAPY	66.00	0 45.09
45.10 ATHLETIC TRAINING -OTH REV	B	-15,000		PHYSICAL THERAPY	66.00	0 45.10
45.11 MISC REV -OTH REV	B	-61,403		ADMINISTRATIVE & GENERAL	5.00	0 45.11
45.12 IHA AND AHA LOBBYING	A	-4,654		ADMINISTRATIVE & GENERAL	5.00	0 45.12
45.13		0			0.00	0 45.13
45.14		0			0.00	0 45.14
45.15		0			0.00	0 45.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,088,692				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet A-8-2

Date/Time Prepared:
5/20/2014 9:29 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	19,961	19,961	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	162,832	162,832	0	0	0	2.00
3.00	60.00	LABORATORY	24,996	0	24,996	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	150	0	150	0	0	4.00
5.00	91.00	EMERGENCY	1,562,970	1,051,953	511,017	0	0	5.00
6.00	93.00	ROCHESTER MEDICAL	1,216,486	1,216,486	0	0	0	6.00
7.00	93.01	ROCHESTER ORTHO	1,935,075	1,935,075	0	0	0	7.00
8.00	93.02	ROCHESTER SURGICAL	1,316,081	1,316,081	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			6,238,551	5,702,388	536,163		0	200.00

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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	19,961	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	162,832	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	1,051,953	5.00
6.00	93.00	ROCHESTER MEDICAL	0	0	0	1,216,486	6.00
7.00	93.01	ROCHESTER ORTHO	0	0	0	1,935,075	7.00
8.00	93.02	ROCHESTER SURGICAL	0	0	0	1,316,081	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	5,702,388	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING		
		1.00	1.02	1.03	1.04		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,338,711	2,338,711				1.00	
1.02 00102 AKRON BUILDING	50,043	0	50,043			1.02	
1.03 00103 ARGOS BUILDING	84,975	0	0	84,975		1.03	
1.04 00101 CLAYS BUILDING	135,333	0	0	0	135,333	1.04	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3,203,257	9,771	0	0	0	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	4,574,973	262,972	5,719	6,798	106	5.00	
7.00 00700 OPERATION OF PLANT	1,491,828	218,864	3,432	7,750	57,466	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	105,980	9,604	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	423,284	24,899	0	0	292	9.00	
10.00 01000 DIETARY	95,622	43,292	0	0	988	10.00	
11.00 01100 CAFETERIA	380,400	70,639	0	0	0	11.00	
13.00 01300 NURSING ADMINISTRATION	186,358	55,197	0	0	0	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00	
15.00 01500 PHARMACY	2,754,098	23,811	0	0	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	748,521	22,347	0	0	3,653	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	3,196,576	348,638	0	0	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	624,725	49,715	0	0	0	31.00	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	2,400,528	163,688	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	441,396	15,819	0	0	0	51.00	
53.00 05300 ANESTHESIOLOGY	48,537	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,613,118	286,846	0	0	0	54.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	1,993,983	57,436	0	0	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	1,309,616	110,834	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	795,015	71,455	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	215,240	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	88,103	0	0	0	0	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	923,013	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
91.00 09100 EMERGENCY	1,700,495	199,635	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00 04040 ROCHESTER MEDICAL	1,350,781	234,641	0	0	24,771	93.00	
93.01 04041 ROCHESTER ORTHO	583,285	0	0	0	38,277	93.01	
93.02 04042 ROCHESTER SURGICAL	208,124	50,741	0	0	0	93.02	
OTHER REIMBURSABLE COST CENTERS							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,065,918	2,330,844	9,151	14,548	125,553	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	3,180,754	0	40,892	70,427	9,780	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 ADVERTISING	355,949	7,867	0	0	0	194.00	
200.00	Cross Foot Adjustments	0	0	0	0	200.00	
201.00	Negative Cost Centers	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	38,602,621	2,338,711	50,043	84,975	135,333	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,213,028				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	353,282	5,203,850	5,203,850		5.00
7.00	00700	OPERATION OF PLANT	45,711	1,825,051	284,361	2,109,412	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,316	119,900	18,682	9,682	148,264
9.00	00900	HOUSEKEEPING	47,646	496,121	77,301	26,029	18,915
10.00	01000	DIETARY	19,901	159,803	24,899	46,784	1,451
11.00	01100	CAFETERIA	32,928	483,967	75,407	71,210	0
13.00	01300	NURSING ADMINISTRATION	22,534	264,089	41,148	55,644	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	43,343	2,821,252	439,579	24,004	0
16.00	01600	MEDICAL RECORDS & LIBRARY	77,875	852,396	132,812	34,150	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	356,146	3,901,360	607,860	351,453	47,989
31.00	03100	INTENSIVE CARE UNIT	72,654	747,094	116,405	50,117	5,804
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	128,945	2,693,161	419,621	165,011	24,719
51.00	05100	RECOVERY ROOM	51,468	508,683	79,258	15,946	5,804
53.00	05300	ANESTHESIOLOGY	0	48,537	7,563	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,657	3,119,621	486,068	289,165	11,608
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	110,069	2,161,488	336,781	57,900	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	157,224	1,577,674	245,817	111,730	10,157
66.00	06600	PHYSICAL THERAPY	104,902	971,372	151,349	72,033	2,902
67.00	06700	OCCUPATIONAL THERAPY	27,785	243,025	37,866	0	0
68.00	06800	SPEECH PATHOLOGY	11,135	99,238	15,462	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	923,013	143,815	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	135,138	2,035,268	317,115	201,249	18,915
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	ROCHESTER MEDICAL	289,231	1,899,424	295,949	315,341	0
93.01	04041	ROCHESTER ORTHO	333,122	954,684	148,749	121,770	0
93.02	04042	ROCHESTER SURGICAL	215,189	474,054	73,862	51,151	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,860,201	34,584,125	4,577,729	2,070,369	148,264
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	342,633	3,644,486	567,847	31,112	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ADVERTISING	10,194	374,010	58,274	7,931	0
200.00		Cross Foot Adjustments		0			200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,213,028	38,602,621	5,203,850	2,109,412	148,264

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
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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						1.00	
1.02	00102						1.02	
1.03	00103						1.03	
1.04	00101						1.04	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900	618,366					9.00	
10.00	01000	2,366	235,303				10.00	
11.00	01100	9,958	0	640,542			11.00	
13.00	01300	2,465	0	2,514	365,860		13.00	
14.00	01400	0	0	0	0	0	14.00	
15.00	01500	6,704	0	15,681	0	0	15.00	
16.00	01600	5,423	0	43,634	0	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	179,535	202,818	127,142	287,616	0	30.00	
31.00	03100	37,169	32,485	20,809	47,088	0	31.00	
41.00	04100	0	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	0	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	79,070	0	61,879	0	0	50.00	
51.00	05100	53,634	0	19,365	0	0	51.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	49,789	0	65,811	31,156	0	54.00	
57.00	05700	0	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	18,831	0	42,265	0	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
65.00	06500	33,324	0	58,693	0	0	65.00	
66.00	06600	18,338	0	34,499	0	0	66.00	
67.00	06700	0	0	0	0	0	67.00	
68.00	06800	0	0	0	0	0	68.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	0	0	0	0	0	88.00	
89.00	08900	0	0	0	0	0	89.00	
91.00	09100	73,155	0	39,477	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	04040	41,408	0	59,116	0	0	93.00	
93.01	04041	0	0	30,267	0	0	93.01	
93.02	04042	5,915	0	15,507	0	0	93.02	
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	0	0	0	0	0	96.00	
99.10	09910	0	0	0	0	0	99.10	
101.00	10100	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		617,084	235,303	636,659	365,860	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
191.00	19100	0	0	0	0	0	191.00	
192.00	19200	0	0	0	0	0	192.00	
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	1,282	0	3,883	0	0	194.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		618,366	235,303	640,542	365,860	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	3,307,220				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,068,415			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	64,114	5,769,887	0	5,769,887
31.00	03100	INTENSIVE CARE UNIT	0	16,449	1,073,420	0	1,073,420
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	135,313	3,578,774	0	3,578,774
51.00	05100	RECOVERY ROOM	0	17,279	699,969	0	699,969
53.00	05300	ANESTHESIOLOGY	0	17,407	73,507	0	73,507
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	217,713	4,270,931	0	4,270,931
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	177,282	2,794,547	0	2,794,547
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	72,358	2,109,753	0	2,109,753
66.00	06600	PHYSICAL THERAPY	0	22,505	1,272,998	0	1,272,998
67.00	06700	OCCUPATIONAL THERAPY	0	6,757	287,648	0	287,648
68.00	06800	SPEECH PATHOLOGY	0	1,714	116,414	0	116,414
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	22,020	1,088,848	0	1,088,848
73.00	07300	DRUGS CHARGED TO PATIENTS	3,307,220	182,128	3,489,348	0	3,489,348
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	0	97,024	2,782,203	0	2,782,203
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	ROCHESTER MEDICAL	0	9,932	2,621,170	0	2,621,170
93.01	04041	ROCHESTER ORTHO	0	6,303	1,261,773	0	1,261,773
93.02	04042	ROCHESTER SURGICAL	0	2,117	622,606	0	622,606
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,307,220	1,068,415	33,913,796	0	33,913,796
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,243,445	0	4,243,445
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ADVERTISING	0	0	445,380	0	445,380
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,307,220	1,068,415	38,602,621	0	38,602,621

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
		1.00	1.02	1.03	1.04	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02 00102	AKRON BUILDING					1.02
1.03 00103	ARGOS BUILDING					1.03
1.04 00101	CLAYS BUILDING					1.04
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,771	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	262,972	5,719	6,798	106
7.00 00700	OPERATION OF PLANT	0	218,864	3,432	7,750	57,466
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,604	0	0	0
9.00 00900	HOUSEKEEPING	0	24,899	0	0	292
10.00 01000	DIETARY	0	43,292	0	0	988
11.00 01100	CAFETERIA	0	70,639	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	55,197	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	23,811	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	22,347	0	0	3,653
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	348,638	0	0	0
31.00 03100	INTENSIVE CARE UNIT	0	49,715	0	0	0
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	163,688	0	0	0
51.00 05100	RECOVERY ROOM	0	15,819	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	286,846	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	0	57,436	0	0	0
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	110,834	0	0	0
66.00 06600	PHYSICAL THERAPY	0	71,455	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	0	199,635	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 04040	ROCHESTER MEDICAL	0	234,641	0	0	24,771
93.01 04041	ROCHESTER ORTHO	0	0	0	0	38,277
93.02 04042	ROCHESTER SURGICAL	0	50,741	0	0	0
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,330,844	9,151	14,548	125,553
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	40,892	70,427	9,780
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	ADVERTISING	0	7,867	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	2,338,711	50,043	84,975	135,333

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
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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	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,771	9,771			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	275,595	1,075	276,670		5.00
7.00	00700	OPERATION OF PLANT	287,512	139	15,119	302,770	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,604	13	993	1,390	12,000
9.00	00900	HOUSEKEEPING	25,191	145	4,110	3,736	1,531
10.00	01000	DIETARY	44,280	61	1,324	6,715	117
11.00	01100	CAFETERIA	70,639	100	4,009	10,221	0
13.00	01300	NURSING ADMINISTRATION	55,197	69	2,188	7,987	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	23,811	132	23,371	3,445	0
16.00	01600	MEDICAL RECORDS & LIBRARY	26,000	237	7,061	4,902	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	348,638	1,078	32,314	50,443	3,883
31.00	03100	INTENSIVE CARE UNIT	49,715	221	6,189	7,193	470
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	163,688	392	22,310	23,685	2,001
51.00	05100	RECOVERY ROOM	15,819	157	4,214	2,289	470
53.00	05300	ANESTHESIOLOGY	0	0	402	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	286,846	668	25,843	41,505	940
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	57,436	335	17,906	8,311	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	110,834	478	13,069	16,037	822
66.00	06600	PHYSICAL THERAPY	71,455	319	8,047	10,339	235
67.00	06700	OCCUPATIONAL THERAPY	0	85	2,013	0	0
68.00	06800	SPEECH PATHOLOGY	0	34	822	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	7,646	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	199,635	411	16,860	28,886	1,531
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	ROCHESTER MEDICAL	259,412	880	15,735	45,262	0
93.01	04041	ROCHESTER ORTHO	38,277	1,014	7,909	17,478	0
93.02	04042	ROCHESTER SURGICAL	50,741	655	3,927	7,342	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,480,096	8,698	243,381	297,166	12,000
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	121,099	1,042	30,191	4,466	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ADVERTISING	7,867	31	3,098	1,138	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,609,062	9,771	276,670	302,770	12,000

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B
Part II
Date/Time Prepared:
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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						1.00
1.02	00102						1.02
1.03	00103						1.03
1.04	00101						1.04
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	34,713					9.00
10.00	01000		52,630				10.00
11.00	01100	559	0	85,528			11.00
13.00	01300	138	0	336	65,915		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	376	0	2,094	0	0	15.00
16.00	01600	304	0	5,826	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,078	45,364	16,979	51,818	0	30.00
31.00	03100	2,087	7,266	2,778	8,484	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,439	0	8,262	0	0	50.00
51.00	05100	3,011	0	2,586	0	0	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	2,795	0	8,787	5,613	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,057	0	5,643	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,871	0	7,837	0	0	65.00
66.00	06600	1,029	0	4,606	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	4,107	0	5,271	0	0	91.00
92.00	09200						92.00
93.00	04040	2,325	0	7,893	0	0	93.00
93.01	04041	0	0	4,041	0	0	93.01
93.02	04042	332	0	2,071	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		34,641	52,630	85,010	65,915	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	72	0	518	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		34,713	52,630	85,528	65,915	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/20/2014 9:29 am	
Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02 00102	AKRON BUILDING					1.02
1.03 00103	ARGOS BUILDING					1.03
1.04 00101	CLAYS BUILDING					1.04
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY	53,229				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	44,330			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	2,662	563,257	0	563,257
31.00 03100	INTENSIVE CARE UNIT	0	683	85,086	0	85,086
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	5,618	230,395	0	230,395
51.00 05100	RECOVERY ROOM	0	717	29,263	0	29,263
53.00 05300	ANESTHESIOLOGY	0	723	1,125	0	1,125
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	9,009	382,006	0	382,006
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	7,361	98,049	0	98,049
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	3,004	153,952	0	153,952
66.00 06600	PHYSICAL THERAPY	0	934	96,964	0	96,964
67.00 06700	OCCUPATIONAL THERAPY	0	281	2,379	0	2,379
68.00 06800	SPEECH PATHOLOGY	0	71	927	0	927
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	914	8,560	0	8,560
73.00 07300	DRUGS CHARGED TO PATIENTS	53,229	7,562	60,791	0	60,791
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	4,029	260,730	0	260,730
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	ROCHESTER MEDICAL	0	412	331,919	0	331,919
93.01 04041	ROCHESTER ORTHO	0	262	68,981	0	68,981
93.02 04042	ROCHESTER SURGICAL	0	88	65,156	0	65,156
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	53,229	44,330	2,439,540	0	2,439,540
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	156,798	0	156,798
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	ADVERTISING	0	0	12,724	0	12,724
200.00	Cross Foot Adjustments			0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	53,229	44,330	2,609,062	0	2,609,062

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B-1

Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		
		NEW BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)			
		1.00	1.02	1.03	1.04			4.00
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	111,772					1.00
1.02	00102	AKRON BUILDING	0	3,500				1.02
1.03	00103	ARGOS BUILDING	0	0	7,500			1.03
1.04	00101	CLAYS BUILDING	0	0	0	20,411		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	467	0	0	0	20,933,166	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,568	400	600	16	2,301,660	5.00
7.00	00700	OPERATION OF PLANT	10,460	240	684	8,667	297,810	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	459	0	0	0	28,122	8.00
9.00	00900	HOUSEKEEPING	1,190	0	0	44	310,415	9.00
10.00	01000	DIETARY	2,069	0	0	149	129,658	10.00
11.00	01100	CAFETERIA	3,376	0	0	0	214,530	11.00
13.00	01300	NURSING ADMINISTRATION	2,638	0	0	0	146,813	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,138	0	0	0	282,381	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,068	0	0	551	507,362	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,662	0	0	0	2,320,354	30.00
31.00	03100	INTENSIVE CARE UNIT	2,376	0	0	0	473,348	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,823	0	0	0	840,087	50.00
51.00	05100	RECOVERY ROOM	756	0	0	0	335,320	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,709	0	0	0	1,431,082	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,745	0	0	0	717,111	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,297	0	0	0	1,024,328	65.00
66.00	06600	PHYSICAL THERAPY	3,415	0	0	0	683,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	181,019	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	72,546	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	9,541	0	0	0	880,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	11,214	0	0	3,736	1,884,363	93.00
93.01	04041	ROCHESTER ORTHO	0	0	0	5,773	2,170,318	93.01
93.02	04042	ROCHESTER SURGICAL	2,425	0	0	0	1,401,971	93.02
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	111,396	640	1,284	18,936	18,634,472	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,860	6,216	1,475	2,232,279	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	376	0	0	0	66,415	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)	2,338,711	50,043	84,975	135,333	3,213,028	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.923943	14.298000	11.330000	6.630395	0.153490	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,771	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000467	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B-1

Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,203,850	33,398,771			5.00
7.00	00700	OPERATION OF PLANT	0	1,825,051	100,005		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,900	459	2,861	8.00
9.00	00900	HOUSEKEEPING	0	496,121	1,234	365	31,360
10.00	01000	DIETARY	0	159,803	2,218	28	120
11.00	01100	CAFETERIA	0	483,967	3,376	0	505
13.00	01300	NURSING ADMINISTRATION	0	264,089	2,638	0	125
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	2,821,252	1,138	0	340
16.00	01600	MEDICAL RECORDS & LIBRARY	0	852,396	1,619	0	275
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,901,360	16,662	926	9,105
31.00	03100	INTENSIVE CARE UNIT	0	747,094	2,376	112	1,885
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,693,161	7,823	477	4,010
51.00	05100	RECOVERY ROOM	0	508,683	756	112	2,720
53.00	05300	ANESTHESIOLOGY	0	48,537	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,119,621	13,709	224	2,525
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	2,161,488	2,745	0	955
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	1,577,674	5,297	196	1,690
66.00	06600	PHYSICAL THERAPY	0	971,372	3,415	56	930
67.00	06700	OCCUPATIONAL THERAPY	0	243,025	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	99,238	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	923,013	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	0	2,035,268	9,541	365	3,710
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	ROCHESTER MEDICAL	0	1,899,424	14,950	0	2,100
93.01	04041	ROCHESTER ORTHO	0	954,684	5,773	0	0
93.02	04042	ROCHESTER SURGICAL	0	474,054	2,425	0	300
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,203,850	29,380,275	98,154	2,861	31,295
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,644,486	1,475	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ADVERTISING	0	374,010	376	0	65
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		5,203,850	2,109,412	148,264	618,366
203.00		Unit cost multiplier (Wkst. B, Part I)		0.155810	21.093065	51.822440	19.718304
204.00		Cost to be allocated (per Wkst. B, Part II)		276,670	302,770	12,000	34,713
205.00		Unit cost multiplier (Wkst. B, Part II)		0.008284	3.027549	4.194338	1.106920

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B-1

Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.02	00102						1.02
1.03	00103						1.03
1.04	00101						1.04
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	4,462					10.00
11.00	01100	0	25,734				11.00
13.00	01300	0	101	135,147			13.00
14.00	01400	0	0	0	1,736,777		14.00
15.00	01500	0	630	0	0	100	15.00
16.00	01600	0	1,753	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,846	5,108	106,244	148,252	0	30.00
31.00	03100	616	836	17,394	19,784	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,486	0	1,121,382	0	50.00
51.00	05100	0	778	0	44,475	0	51.00
53.00	05300	0	0	0	17,466	0	53.00
54.00	05400	0	2,644	11,509	89,910	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	1,698	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	2,358	0	15,482	0	65.00
66.00	06600	0	1,386	0	7,974	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	100	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	1,586	0	64,362	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	2,375	0	117,523	0	93.00
93.01	04041	0	1,216	0	35,818	0	93.01
93.02	04042	0	623	0	278	0	93.02
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		4,462	25,578	135,147	1,682,706	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	54,071	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	156	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		235,303	640,542	365,860	0	3,307,220	202.00
203.00		52.734872	24.890884	2.707126	0.000000	33,072.200000	203.00
204.00		52,630	85,528	65,915	0	53,229	204.00
205.00		11.795159	3.323541	0.487728	0.000000	532.290000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
1.02	00102	AKRON BUILDING	1.02
1.03	00103	ARGOS BUILDING	1.03
1.04	00101	CLAYS BUILDING	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		90,723,678	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - I RF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
		5,444,026	
		1,396,739	
		0	
		0	
		0	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		11,489,609	
		1,467,164	
		1,478,036	
		18,489,475	
		0	
		0	
		0	
		15,053,201	
		0	
		6,144,019	
		1,910,890	
		573,787	
		145,552	
		0	
		1,869,751	
		15,464,715	
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04040	ROCHESTER MEDICAL	93.00
93.01	04041	ROCHESTER ORTHO	93.01
93.02	04042	ROCHESTER SURGICAL	93.02
		8,238,468	
		843,355	
		535,169	
		179,722	
OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
		0	
		0	
		0	
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		90,723,678	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	ADVERTISING	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		1,068,415	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.011777	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		44,330	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000489	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/20/2014 9:29 am

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	5,769,887		5,769,887	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1,073,420		1,073,420	0	0	31.00
41.00	04100 SUBPROVIDER - I RF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,578,774		3,578,774	0	0	50.00
51.00	05100 RECOVERY ROOM	699,969		699,969	0	0	51.00
53.00	05300 ANESTHESIOLOGY	73,507		73,507	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,270,931		4,270,931	0	0	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	2,794,547		2,794,547	0	0	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	2,109,753	0	2,109,753	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,272,998	0	1,272,998	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	287,648	0	287,648	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	116,414	0	116,414	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,088,848		1,088,848	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,489,348		3,489,348	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100 EMERGENCY	2,782,203		2,782,203	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	870,920		870,920	0	0	92.00
93.00	04040 ROCHESTER MEDICAL	2,621,170		2,621,170	0	0	93.00
93.01	04041 ROCHESTER ORTHO	1,261,773		1,261,773	0	0	93.01
93.02	04042 ROCHESTER SURGICAL	622,606		622,606	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
99.10	09910 CORF	0		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	34,784,716	0	34,784,716	0	0	200.00
201.00	Less Observation Beds	870,920		870,920			201.00
202.00	Total (see instructions)	33,913,796	0	33,913,796	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 151313		Period: From 01/01/2013 To 12/31/2013		Worksheet C Part I Date/Time Prepared: 5/20/2014 9:29 am	
			Title XVIII		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,464,611		4,464,611			30.00
31.00	03100	INTENSIVE CARE UNIT	1,396,739		1,396,739			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,294,576	8,195,033	11,489,609	0.311479	0.000000	50.00
51.00	05100	RECOVERY ROOM	321,573	1,145,591	1,467,164	0.477090	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	248,455	1,229,581	1,478,036	0.049733	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,452,116	17,037,359	18,489,475	0.230993	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,519,326	12,533,875	15,053,201	0.185645	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,388,223	3,755,796	6,144,019	0.343383	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	338,536	1,572,354	1,910,890	0.666181	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,488	466,299	573,787	0.501315	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,043	127,509	145,552	0.799810	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,578,591	291,160	1,869,751	0.582349	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,529,382	10,935,333	15,464,715	0.225633	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	102,985	8,135,483	8,238,468	0.337709	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	979,415	979,415	0.889225	0.000000	92.00
93.00	04040	ROCHESTER MEDICAL	12,964	830,391	843,355	3.108027	0.000000	93.00
93.01	04041	ROCHESTER ORTHO	31,305	503,864	535,169	2.357709	0.000000	93.01
93.02	04042	ROCHESTER SURGICAL	0	179,722	179,722	3.464273	0.000000	93.02
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,804,913	67,918,765	90,723,678			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,804,913	67,918,765	90,723,678			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/20/2014 9:29 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 ROCHESTER MEDICAL	0.000000		93.00
93.01	04041 ROCHESTER ORTHO	0.000000		93.01
93.02	04042 ROCHESTER SURGICAL	0.000000		93.02
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
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: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5,769,887		5,769,887	0	5,769,887 30.00
31.00	03100 INTENSIVE CARE UNIT	1,073,420		1,073,420	0	1,073,420 31.00
41.00	04100 SUBPROVIDER - I RF	0		0	0	0 41.00
42.00	04200 SUBPROVIDER	0		0	0	0 42.00
43.00	04300 NURSERY	0		0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,578,774		3,578,774	0	3,578,774 50.00
51.00	05100 RECOVERY ROOM	699,969		699,969	0	699,969 51.00
53.00	05300 ANESTHESIOLOGY	73,507		73,507	0	73,507 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,270,931		4,270,931	0	4,270,931 54.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	2,794,547		2,794,547	0	2,794,547 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	2,109,753	0	2,109,753	0	2,109,753 65.00
66.00	06600 PHYSICAL THERAPY	1,272,998	0	1,272,998	0	1,272,998 66.00
67.00	06700 OCCUPATIONAL THERAPY	287,648	0	287,648	0	287,648 67.00
68.00	06800 SPEECH PATHOLOGY	116,414	0	116,414	0	116,414 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,088,848		1,088,848	0	1,088,848 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,489,348		3,489,348	0	3,489,348 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
91.00	09100 EMERGENCY	2,782,203		2,782,203	0	2,782,203 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	870,920		870,920	0	870,920 92.00
93.00	04040 ROCHESTER MEDICAL	2,621,170		2,621,170	0	2,621,170 93.00
93.01	04041 ROCHESTER ORTHO	1,261,773		1,261,773	0	1,261,773 93.01
93.02	04042 ROCHESTER SURGICAL	622,606		622,606	0	622,606 93.02
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
99.10	09910 CORF	0		0	0	0 99.10
101.00	10100 HOME HEALTH AGENCY	0		0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	34,784,716	0	34,784,716	0	34,784,716 200.00
201.00	Less Observation Beds	870,920		870,920		870,920 201.00
202.00	Total (see instructions)	33,913,796	0	33,913,796	0	33,913,796 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/20/2014 9:29 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,464,611		4,464,611		30.00
31.00	03100	INTENSIVE CARE UNIT	1,396,739		1,396,739		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,294,576	8,195,033	11,489,609	0.311479	50.00
51.00	05100	RECOVERY ROOM	321,573	1,145,591	1,467,164	0.477090	51.00
53.00	05300	ANESTHESIOLOGY	248,455	1,229,581	1,478,036	0.049733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,452,116	17,037,359	18,489,475	0.230993	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,519,326	12,533,875	15,053,201	0.185645	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,388,223	3,755,796	6,144,019	0.343383	65.00
66.00	06600	PHYSICAL THERAPY	338,536	1,572,354	1,910,890	0.666181	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,488	466,299	573,787	0.501315	67.00
68.00	06800	SPEECH PATHOLOGY	18,043	127,509	145,552	0.799810	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,578,591	291,160	1,869,751	0.582349	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,529,382	10,935,333	15,464,715	0.225633	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	102,985	8,135,483	8,238,468	0.337709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	979,415	979,415	0.889225	92.00
93.00	04040	ROCHESTER MEDICAL	12,964	830,391	843,355	3.108027	93.00
93.01	04041	ROCHESTER ORTHO	31,305	503,864	535,169	2.357709	93.01
93.02	04042	ROCHESTER SURGICAL	0	179,722	179,722	3.464273	93.02
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	22,804,913	67,918,765	90,723,678		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	22,804,913	67,918,765	90,723,678		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/20/2014 9:29 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 ROCHESTER MEDICAL	0.000000		93.00
93.01	04041 ROCHESTER ORTHO	0.000000		93.01
93.02	04042 ROCHESTER SURGICAL	0.000000		93.02
	OTHER REIMBURSABLE COST CENTERS			
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
	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: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/20/2014 9:29 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	230,395	11,489,609	0.020052	836,079	16,765	50.00
51.00	05100 RECOVERY ROOM	29,263	1,467,164	0.019945	71,105	1,418	51.00
53.00	05300 ANESTHESIOLOGY	1,125	1,478,036	0.000761	58,283	44	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	382,006	18,489,475	0.020661	529,041	10,931	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	98,049	15,053,201	0.006513	943,186	6,143	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	153,952	6,144,019	0.025057	1,123,565	28,153	65.00
66.00	06600 PHYSICAL THERAPY	96,964	1,910,890	0.050743	185,012	9,388	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,379	573,787	0.004146	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	927	145,552	0.006369	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,560	1,869,751	0.004578	587,743	2,691	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	60,791	15,464,715	0.003931	1,750,474	6,881	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	260,730	8,238,468	0.031648	4,795	152	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	979,415	0.000000	0	0	92.00
93.00	04040 ROCHESTER MEDICAL	331,919	843,355	0.393570	1,333	525	93.00
93.01	04041 ROCHESTER ORTHO	68,981	535,169	0.128896	0	0	93.01
93.02	04042 ROCHESTER SURGICAL	65,156	179,722	0.362538	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	1,791,197	84,862,328		6,090,616	83,091	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	ROCHESTER MEDICAL	0	0	0	0	0	93.00
93.01	04041	ROCHESTER ORTHO	0	0	0	0	0	93.01
93.02	04042	ROCHESTER SURGICAL	0	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/20/2014 9:29 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	11,489,609	0.000000	0.000000	836,079	50.00
51.00	05100 RECOVERY ROOM	0	1,467,164	0.000000	0.000000	71,105	51.00
53.00	05300 ANESTHESIOLOGY	0	1,478,036	0.000000	0.000000	58,283	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,489,475	0.000000	0.000000	529,041	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	15,053,201	0.000000	0.000000	943,186	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	6,144,019	0.000000	0.000000	1,123,565	65.00
66.00	06600 PHYSICAL THERAPY	0	1,910,890	0.000000	0.000000	185,012	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	573,787	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	145,552	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,869,751	0.000000	0.000000	587,743	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	15,464,715	0.000000	0.000000	1,750,474	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	8,238,468	0.000000	0.000000	4,795	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	979,415	0.000000	0.000000	0	92.00
93.00	04040 ROCHESTER MEDICAL	0	843,355	0.000000	0.000000	1,333	93.00
93.01	04041 ROCHESTER ORTHO	0	535,169	0.000000	0.000000	0	93.01
93.02	04042 ROCHESTER SURGICAL	0	179,722	0.000000	0.000000	0	93.02
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	84,862,328			6,090,616	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/20/2014 9:29 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 ROCHESTER MEDICAL	0	0	0		93.00
93.01	04041 ROCHESTER ORTHO	0	0	0		93.01
93.02	04042 ROCHESTER SURGICAL	0	0	0		93.02
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/20/2014 9:29 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.311479	0	1,488,121	0	0
51.00 05100 RECOVERY ROOM	0.477090	0	207,508	0	0
53.00 05300 ANESTHESIOLOGY	0.049733	0	251,028	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.230993	0	4,242,095	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.185645	0	3,470,779	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.343383	0	1,169,932	0	0
66.00 06600 PHYSICAL THERAPY	0.666181	0	524,174	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.501315	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.799810	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.582349	0	59,641	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.225633	0	4,604,884	2,259	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.337709	0	1,846,834	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.889225	0	255,454	0	0
93.00 04040 ROCHESTER MEDICAL	3.108027	0	44,868	819	0
93.01 04041 ROCHESTER ORTHO	2.357709	0	44,668	0	0
93.02 04042 ROCHESTER SURGICAL	3.464273	0	13,891	0	0
OTHER REIMBURSABLE COST CENTERS					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	18,223,877	3,078	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	18,223,877	3,078	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/20/2014 9:29 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	463,518	0		50.00
51.00 05100 RECOVERY ROOM	99,000	0		51.00
53.00 05300 ANESTHESIOLOGY	12,484	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	979,894	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	644,333	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	401,735	0		65.00
66.00 06600 PHYSICAL THERAPY	349,195	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	34,732	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,039,014	510		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	623,692	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	227,156	0		92.00
93.00 04040 ROCHESTER MEDICAL	139,451	2,545		93.00
93.01 04041 ROCHESTER ORTHO	105,314	0		93.01
93.02 04042 ROCHESTER SURGICAL	48,122	0		93.02
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	5,167,640	3,055		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,167,640	3,055		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/20/2014 9:29 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.311479	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.477090	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.049733	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.230993	0	0	0	0	54.00
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.185645	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0.343383	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.666181	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.501315	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.799810	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.582349	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.225633	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00 09100 EMERGENCY	0.337709	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.889225	0	0	0	0	92.00
93.00 04040 ROCHESTER MEDICAL	3.108027	0	0	0	0	93.00
93.01 04041 ROCHESTER ORTHO	2.357709	0	0	0	0	93.01
93.02 04042 ROCHESTER SURGICAL	3.464273	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/20/2014 9:29 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 ROCHESTER MEDICAL	0	0		93.00
93.01 04041 ROCHESTER ORTHO	0	0		93.01
93.02 04042 ROCHESTER SURGICAL	0	0		93.02
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII		Hospital
				Date/Time Prepared: 5/20/2014 9:29 am
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)		4,930	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,796	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)		4,062	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		59	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		75	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)		1,365	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)		58	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		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,769,887	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)		9,249	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)		79,255	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,690,632	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)		5,690,632	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)		1,186.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,619,627	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)		1,619,627	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/20/2014 9:29 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,073,420	616	1,742.56	277	482,689		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)					1,846,609		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,948,925		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)					68,819		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)					68,819		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/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR 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)						734	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,186.54	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						870,920	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/20/2014 9:29 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/20/2014 9:29 am
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)		4,930	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,796	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)		4,062	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		59	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		75	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)		181	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)		58	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		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,769,887	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)		9,249	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)		79,255	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,690,632	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)		5,690,632	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)		1,186.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		214,764	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)		214,764	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Date/Time Prepared: 5/20/2014 9:29 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,073,420	616	1,742.56	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						207,533	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						422,297	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)						68,819	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)						68,819	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/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR 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)						734	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,186.54	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						870,920	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/20/2014 9:29 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/20/2014 9:29 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,441,480	30.00
31.00	03100	INTENSIVE CARE UNIT		634,605	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311479	836,079	50.00
51.00	05100	RECOVERY ROOM	0.477090	71,105	51.00
53.00	05300	ANESTHESIOLOGY	0.049733	58,283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230993	529,041	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.185645	943,186	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.343383	1,123,565	65.00
66.00	06600	PHYSICAL THERAPY	0.666181	185,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.501315	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.799810	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.582349	587,743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225633	1,750,474	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.337709	4,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.889225	0	92.00
93.00	04040	ROCHESTER MEDICAL	3.108027	1,333	93.00
93.01	04041	ROCHESTER ORTHO	2.357709	0	93.01
93.02	04042	ROCHESTER SURGICAL	3.464273	0	93.02
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		6,090,616	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)		6,090,616	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z313		Date/Time Prepared: 5/20/2014 9:29 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		26,100	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311479	2,367	737 50.00
51.00	05100	RECOVERY ROOM	0.477090	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0.049733	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230993	4,296	992 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.185645	6,918	1,284 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.343383	21,709	7,455 65.00
66.00	06600	PHYSICAL THERAPY	0.666181	22,876	15,240 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.501315	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.799810	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.582349	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225633	46,469	10,485 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
91.00	09100	EMERGENCY	0.337709	9	3 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.889225	0	0 92.00
93.00	04040	ROCHESTER MEDICAL	3.108027	0	0 93.00
93.01	04041	ROCHESTER ORTHO	2.357709	0	0 93.01
93.02	04042	ROCHESTER SURGICAL	3.464273	0	0 93.02
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
200.00		Total (sum of lines 50-94 and 96-98)		104,644	36,196 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		104,644	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/20/2014 9:29 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		258,630	30.00
31.00	03100	INTENSIVE CARE UNIT		41,825	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311479	187,629	58,442 50.00
51.00	05100	RECOVERY ROOM	0.477090	27,396	13,070 51.00
53.00	05300	ANESTHESIOLOGY	0.049733	16,839	837 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230993	44,914	10,375 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.185645	128,868	23,924 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.343383	72,785	24,993 65.00
66.00	06600	PHYSICAL THERAPY	0.666181	5,674	3,780 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.501315	2,133	1,069 67.00
68.00	06800	SPEECH PATHOLOGY	0.799810	265	212 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.582349	36,164	21,060 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225633	184,307	41,586 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
91.00	09100	EMERGENCY	0.337709	24,237	8,185 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.889225	0	0 92.00
93.00	04040	ROCHESTER MEDICAL	3.108027	0	0 93.00
93.01	04041	ROCHESTER ORTHO	2.357709	0	0 93.01
93.02	04042	ROCHESTER SURGICAL	3.464273	0	0 93.02
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
200.00		Total (sum of lines 50-94 and 96-98)		731,211	207,533 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		731,211	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/20/2014 9:29 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,170,695 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,170,695 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 Worksheet D-4, Part III, line 69, col. 4)			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 charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,222,402 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			26,973 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,972,580 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,222,849 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,222,849 30.00
31.00	Primary payer payments			1,808 31.00
32.00	Subtotal (line 30 minus line 31)			2,221,041 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			365,667 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			321,787 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			365,667 36.00
37.00	Subtotal (see instructions)			2,542,828 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,542,828 40.00
40.01	Sequestration adjustment (see instructions)			38,397 40.01
41.00	Interim payments			2,376,991 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			127,440 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 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: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2014 9:29 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,286,307		2,376,991	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	06/25/2013	109,700		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)		109,700		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)		3,396,007		2,376,991	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		258,119		127,440	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,654,126		2,504,431	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151313
Component CCN: 15Z313

Period:
From 01/01/2013
To 12/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2014 9:29 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		95,881		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)		95,881		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		8,582		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		104,463		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet E-1
Part II
Date/Time Prepared:
5/20/2014 9:29 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,227 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,642 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			913 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			4,678 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			90,723,678 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,883,267 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			223,972 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			171,137 8.00
9.00	Sequestration adjustment amount (see instructions)			3,423 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			167,714 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			167,714 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151313
Component CCN: 15Z313

Period:
From 01/01/2013
To 12/31/2013

Worksheet E-2
Date/Time Prepared:
5/20/2014 9:29 am

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	69,507	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	36,558	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	58	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)	106,065	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	106,065	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)	106,065	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	106,065	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
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)	106,065	0	19.00	
19.01	Sequestration adjustment (see instructions)	1,602	0	19.01	
20.00	Interim payments	95,881	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	8,582	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/20/2014 9:29 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			3,948,925 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			3,948,925 4.00
5.00	Primary payer payments			7,620 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,980,794 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 teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (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)			3,980,794 19.00
20.00	Deductibles (exclude professional component)			370,592 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,610,202 22.00
23.00	Coinsurance			4,736 23.00
24.00	Subtotal (line 22 minus line 23)			3,605,466 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			118,958 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			104,683 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			118,958 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,710,149 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			3,710,149 30.00
30.01	Sequestration adjustment (see instructions)			56,023 30.01
31.00	Interim payments			3,396,007 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			258,119 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2014 9:29 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		422,297		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		422,297	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		422,297	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		300,455		8.00
9.00	Ancillary service charges		731,211	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,031,666	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,031,666	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		609,369	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		422,297	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		422,297	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		422,297	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		422,297	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		422,297	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		422,297	0	40.00
41.00	Interim payments		418,953	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		3,344	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet G

Date/Time Prepared:
5/20/2014 9:29 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,902,477	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	7,084,578	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,150,234	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	4,394,746	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,532,035	0	0	0	11.00
FIXED ASSETS						
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	489,727	0	0	0	13.00
14.00	Accumulated depreciation	-369,341	0	0	0	14.00
15.00	Buildings	26,175,269	0	0	0	15.00
16.00	Accumulated depreciation	-9,531,084	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	8,318,521	0	0	0	23.00
24.00	Accumulated depreciation	-5,602,055	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)	20,077,253	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,934,093	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,934,093	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,543,381	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,092,984	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,218,640	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,018,400	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,330,024	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	14,073,228	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,073,228	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,403,252	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,140,129				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)	15,140,129	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,543,381	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet G-1

Date/Time Prepared:
5/20/2014 9:29 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		14,553,633		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		586,496			2.00
3.00	Total (sum of line 1 and line 2)		15,140,129		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		15,140,129		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,140,129		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/20/2014 9:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,338,708		5,338,708	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,338,708		5,338,708	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,502,057		1,502,057	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)	1,502,057		1,502,057	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,840,765		6,840,765	17.00
18.00	Ancillary services	16,801,088	57,431,745	74,232,833	18.00
19.00	Outpatient services	1,305,334	17,733,883	19,039,217	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICES	0	4,907,189	4,907,189	27.00
27.01	MISC REVENUE	0	1,344	1,344	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,947,187	80,074,161	105,021,348	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,691,313		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)		47,691,313		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151313

Period:
From 01/01/2013
To 12/31/2013

Worksheet G-3

Date/Time Prepared:
5/20/2014 9:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	105,021,348	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,153,139	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,868,209	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,691,313	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-823,104	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,376,175	24.00
24.01	INVESTMENT INCOME	7,480	24.01
24.02	LOSS ON DISPOSITION OF ASSETS	-1,974	24.02
24.03	OTHER NONOPERATING INCOME (EXPENSE)	27,919	24.03
25.00	Total other income (sum of lines 6-24)	1,409,600	25.00
26.00	Total (line 5 plus line 25)	586,496	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	586,496	29.00