IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 04/12/2017 Time: 15:52 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] 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. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] 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 IROQUOIS MEMORIAL HOSPITAL (14-0167) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2015 and ending 09/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

N
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-17,031	-28,786			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		-1				7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			37,540			10
10.01	HEALTH CLINIC - RHC II			-4,464			10.01
10.02	HEALTH CLINIC - RHC III			13,101			10.02
10.03	HEALTH CLINIC - RHC IV			28,829			10.03
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-17,032	46,220			200

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 resopnd 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 this 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 this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 200 FAIRMAN AVENUE	P.O. Box:		1
2	City: WATSEKA	State: IL	ZIP Code: 60970	County: IROQUOIS 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	IROQUOIS MEMORIAL HOSPITAL	14-0167	99914	1	07 / 01 / 1996	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	IROQUOIS MEMORIAL HOSPITAL	14-U167	99914		12 / 31 / 2006	N	P	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF	IROQUOIS RESIDENT HOME	14-6049	99914		08 / 18 / 2003	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	IROQUOIS HOME HEALTH	14-7586	99914		09 / 30 / 1994	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice	IROQUOIS MEMORIAL HOSPICE	14-1616	99914		11 / 04 / 2004				14
15	Hospital-Based Health Clinic - RHC	GILMAN CLINIC	14-3424	99914		09 / 04 / 1996	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	MILFORD CLINIC	14-3425	99914		10 / 09 / 1996	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	KENTLAND CLINIC	15-3979	99915		10 / 29 / 1996	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	MPS CLINIC	14-8551	99914		02 / 05 / 2016	N	O	N	15.03
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 10 / 01 / 2015	To: 09 / 30 / 2016	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments 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§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	338			29		43	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	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.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning: 10 / 01 / 2015	Ending: 09 / 30 / 2016	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01

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WORKSHEET S-2
PART I

38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	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)	Y	Y	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	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
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

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.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	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.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	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
71	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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	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
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

		1	2	
Rural Providers				
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	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 each therapy.		N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	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
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	425,429			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	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.		Y	N	120
121	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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	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
127	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
128	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
129	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
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	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
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	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
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	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

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	Name:	Contractor's Name:	Contractor's Number:		141
142	Street:	P.O. Box:			142
143	City:	State:	ZIP Code:		143
144	Are provider based physicians' costs included in Worksheet A?		Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.		N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.		N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.		N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.		N		149

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)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	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)	9.99			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2015	09 / 30 / 2016	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

		Y/N	Date		
Provider Organization and Operation		1	2		
1	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
		Y/N	Date	V/I	
		1	2	3	
2	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
3	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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	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
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	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	01/09/2017	Y	01/09/2017	16
17	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
18	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 the cost report? If yes, see instructions.	N		N		18
19	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
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	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.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	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.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	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
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: BRENT	Last name: KOCHEL	Title: MANAGER	41
42	Employer: KERBER, ECK & BRAECKEL LLP			42
43	Phone number: 618-529-1040	E-mail Address: BRENTK@KEBCPA.COM		43

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	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	25	9,150			1,064	218	1,710	1
2	HMO and other (see instructions)						73	72		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,150			1,064	218	1,710	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						100	138	13
14	Total (see instructions)		25	9,150			1,064	318	1,848	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	35	12,810			1,685		11,312	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,885		5,137	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116	1	366					1	24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					2,105		5,799	26
26.01	RHC II	88.01					1,471		3,934	26.01
26.02	RHC III	88.02					3,628		8,557	26.02
26.03	RHC IV	88.03					2,081		6,357	26.03
27	Total (sum of lines 14-26)		61							27
28	Observation Bed Days							94	612	28
29	Ambulance Trips						1,639			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							20	30	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	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)					378	138	666	1
2	HMO and other (see instructions)					26			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		233.80			378	138	666	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		28.26						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		9.62						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		15.14						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		7.21						26
26.01	RHC II		4.43						26.01
26.02	RHC III		10.54						26.02
26.03	RHC IV		8.90						26.03
27	Total (sum of lines 14-26)		317.90						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	17,269,919		17,269,919	707,031.00	24.43	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		1,573,320		1,573,320	15,545.00	101.21	5
6	Non-physician-Part B		490,643		490,643	9,963.00	49.25	6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44	985,404		985,404	58,774.00	16.77	9
10	Excluded area salaries (see instructions)		2,801,619	391,744	3,193,363	128,933.00	24.77	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		614,651		614,651	9,046.00	67.95	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		2,118,732		2,118,732			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		804,476		804,476			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		151,374		151,374			23
24	Wage-related costs (RHC/FQHC)		61,266		61,266			24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		118,091		118,091	4,596.00	25.69	26
27	Administrative & General		1,994,435		1,994,435	85,567.00	23.31	27
28	Administrative & General under contract (see instructions)		169,139		169,139	997.00	169.65	28
29	Maintenance & Repairs							29
30	Operation of Plant		242,030		242,030	15,118.00	16.01	30
31	Laundry & Linen Service		34,786		34,786	3,223.00	10.79	31
32	Housekeeping		273,370		273,370	26,930.00	10.15	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		358,871	-162,492	196,379	17,026.00	11.53	34
35	Dietary under contract (see instructions)		1,238		1,238	19.00	65.16	35
36	Cafeteria			162,492	162,492	14,089.00	11.53	36
37	Maintenance of Personnel							37
38	Nursing Administration		390,573		390,573	9,731.00	40.14	38
39	Central Services and Supply		10		10	1.00	10.00	39
40	Pharmacy							40
41	Medical Records & Medical Records Library		460,582		460,582	21,138.00	21.79	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	15,376,333		15,376,333	682,539.00	22.53	1
2	Excluded area salaries (see instructions)	3,787,023	391,744	4,178,767	187,707.00	22.26	2
3	Subtotal salarles (line 1 minus line 2)	11,589,310	-391,744	11,197,566	494,832.00	22.63	3
4	Subtotal other wages & related costs (see instructions)	614,651		614,651	9,046.00	67.95	4
5	Subtotal wage-related costs (see instructions)	2,118,732		2,118,732		18.92%	5
6	Total (sum of lines 3 through 5)	14,322,693	-391,744	13,930,949	503,878.00	27.65	6
7	Total overhead cost (see instructions)	4,043,125		4,043,125	198,435.00	20.38	7

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HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)	1,685,081	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	209,642	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	966,574	17
18	Medicare Taxes - Employers Portion Only	226,054	18
19	Unemployment Insurance	38,405	19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	10,094	23
24	Total Wage Related cost (Sum of lines 1-23)	3,135,850	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	203,513		1
2	Hospital	203,513		2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
14.01	Hospital-Based Health Clinic - RHC II			14.01
14.02	Hospital-Based Health Clinic - RHC III			14.02
14.03	Hospital-Based Health Clinic - RHC IV			14.03
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7586** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County:

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours		3,328			3,328	1
2	Unduplicated Census Count (see instructions)		182.00	17.00	42.00	241.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)	0.46		0.46	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	0.92		0.92	5
6	Direct Nursing Service	4.30		4.30	6
7	Nursing Supervisor	0.78		0.78	7
8	Physical Therapy Service	1.10		1.10	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	0.11		0.11	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	0.09		0.09	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.04		0.04	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.60		1.60	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	3	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	99914	20
20.01		16580	20.01
20.02		19180	20.02

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	1,348	358	37	27	1,770	21
22	Skilled Nursing Visit Charges	215,981	57,307	5,925	4,361	283,574	22
23	Physical Therapy Visits	925	23	20	35	1,003	23
24	Physical Therapy Visit Charges	147,549	3,649	3,179	5,653	160,030	24
25	Occupational Therapy Visits	122	1	1	1	125	25
26	Occupational Therapy Visit Charges	19,080	157	162	162	19,561	26
27	Speech Pathology Visits	32				32	27
28	Speech Pathology Visit Charges	5,136				5,136	28
29	Medical Social Service Visits	28		1	1	30	29
30	Medical Social Service Visit Charges	5,614		201	201	6,016	30
31	Home Health Aide Visits	430	49	4	6	489	31
32	Home Health Aide Visit Charges	42,618	4,828	395	602	48,443	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,885	431	63	70	3,449	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	435,978	65,941	9,862	10,979	522,760	35
36	Total Number of Episodes (standard/non-outlier)	158		19	6	183	36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges	6,914	776	197		7,887	38

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA	23		23	14
15	RVC	71		71	15
16	RVB	131		131	16
17	RVA	374		374	17
18	RHC	235		235	18
19	RHB	284		284	19
20	RHA	391		391	20
21	RMC	39		39	21
22	RMB	14		14	22
23	RMA	41		41	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1	8		8	34
35	HB2				35
36	HB1	17		17	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	1		1	48
49	CC2				49
50	CC1	4		4	50
51	CB2				51
52	CB1	22		22	52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1	13		13	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1	6		6	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1	8		8	78
199	AAA	3		3	199
200	TOTAL	1,685		1,685	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	00014	00014	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing	985,404	43.84%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	277	0.01%	Y	205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	2,247,854			207

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3424** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 508 E CRESENT	1
2	City: GILMAN State: IL ZIP Code: 60938 County: IROQUOIS	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0830	1830	0700	1700	0700	1700	0830	1830	0830	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3425** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 207 N AXTEL	1
2	City: MILFORD State: IL ZIP Code: 60983 County: IROQUOIS	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0830	1700	0700	1700	0830	1830	0830	1700	0700	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 15-3979** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 303 N SEVENTH	1
2	City: KENTLAND State: IN ZIP Code: 47951 County: NEWTON	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0700	1700	0830	1830	0700	1700	0830	1830	0700	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-8551** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 200 FAIRMAN AVE	1
2	City: WATSEKA State: IL ZIP Code: 60970 County: IROQUOIS	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0700	1700	0830	1830	0700	1700	0830	1830	0700	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA **HOSPICE CCN: 14-1616** **WORKSHEET S-9**
PARTS I THROUGH IV

PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Unduplicated Days				
		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
10	Hospice Continuous Home Care	1			1	10
11	Hospice Routine Home Care	7,951	8	297	8,256	11
12	Hospice Inpatient Respite Care	17			17	12
13	Hospice General Inpatient Care	140		11	151	13
14	Total Hospice Days	8,109	8	308	8,425	14

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
15	Hospice Inpatient Respite Care					15
16	Hospice General Inpatient Care					16

NOTE: Parts I and II, columns 1 and 2 also include the days reported in column 3 and 4.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.392776	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,730,297	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	9,477,688	6
7	Medicaid cost (line 1 times line 6)	3,722,608	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	992,311	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	992,311	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	381,942	271,558	653,500	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	150,018	106,661	256,679	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	150,018	106,661	256,679	23

24	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
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,728,344	26
27	Medicare bad debts for the entire hospital complex (see instructions)	162,333	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,566,011	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	615,092	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	871,771	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,864,082	31

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,711,410	1,711,410	-609,922	1,101,488	-10,738	1,090,750	1
2	00200	Cap Rel Costs-Mvble Equip				906,746	906,746	-960	905,786	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	118,091	1,639,748	1,757,839	330,816	2,088,655	-2,423	2,086,232	4
5.01	00540	ADMISSIONS	341,477	209,971	551,448		551,448	-20,331	531,117	5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	84,239	107,199	191,438	-57,249	134,189		134,189	5.02
5.03	00560	DATA PROCESSING	347,557	360,138	707,695	4,136	711,831		711,831	5.03
5.04	00570	COMMUNICATIONS	11,360	72,948	84,308	8,206	92,514		92,514	5.04
5.05	00580	BUSINESS OFFICE	285,341	-63,672	221,669	143,724	365,393		365,393	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	924,461	1,873,842	2,798,303	6,791	2,805,094	-1,166,428	1,638,666	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	242,030	922,067	1,164,097	60,610	1,224,707	-12,785	1,211,922	7
8	00800	Laundry & Linen Service	34,786	6,688	41,474		41,474		41,474	8
9	00900	Housekeeping	273,370	55,702	329,072		329,072	-1,523	327,549	9
10	01000	Dietary	358,871	333,916	692,787	-313,530	379,257		379,257	10
11	01100	Cafeteria				313,530	313,530	-155,334	158,196	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	390,573	113,623	504,196	-357	503,839	-393	503,446	13
14	01400	Central Services & Supply	10	25,948	25,958		25,958	-286	25,672	14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	460,582	83,075	543,657		543,657	-299	543,358	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,705,331	575,721	2,281,052	-463,218	1,817,834	-15,003	1,802,831	30
43	04300	Nursery		50	50	249,682	249,732		249,732	43
44	04400	Skilled Nursing Facility	985,404	224,321	1,209,725	-21,105	1,188,620	211	1,188,831	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	761,801	1,831,497	2,593,298	-1,059,033	1,534,265	-581,858	952,407	50
52	05200	Delivery Room & Labor Room				171,405	171,405		171,405	52
53	05300	Anesthesiology		660,288	660,288	-8,384	651,904	-651,904		53
54	05400	Radiology-Diagnostic	712,826	843,770	1,556,596	-382,209	1,174,387	-48,277	1,126,110	54
57	05700	CT Scan	105,417	131,981	237,398		237,398		237,398	57
58	05800	MRI	48,230	211,383	259,613		259,613		259,613	58
60	06000	Laboratory	601,277	797,406	1,398,683	-1,169	1,397,514		1,397,514	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	419,809	152,777	572,586	-66,514	506,072	-28,660	477,412	65
66	06600	Physical Therapy	634,488	155,144	789,632	-16,611	773,021	-3,600	769,421	66
69	06900	Electrocardiology	45,500	54,395	99,895	-94	99,801	-14,184	85,617	69
71	07100	Medical Supplies Charged to Patients				657,892	657,892	-91	657,801	71
72	07200	Impl. Dev. Charged to Patients				1,049,529	1,049,529		1,049,529	72
73	07300	Drugs Charged to Patients	415,706	1,765,733	2,181,439	156,230	2,337,669	-297,760	2,039,909	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	676,565	215,173	891,738	-69,284	822,454		822,454	88
88.01	08801	RHC II	307,461	163,937	471,398	-66,058	405,340	-30	405,310	88.01
88.02	08802	RHC III	760,263	321,299	1,081,562	-103,281	978,281		978,281	88.02
88.03	08803	RHC IV	1,250,301	468,054	1,718,355	-514,841	1,203,514		1,203,514	88.03
90	09000	Clinic	272,370	-103,389	168,981	-29,665	139,316	-116,761	22,555	90
91	09100	Emergency	892,803	750,935	1,643,738	-43,936	1,599,802	-538,085	1,061,717	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	717,262	262,643	979,905	-41,229	938,676	-67,851	870,825	95
101	10100	Home Health Agency	560,723	160,586	721,309	-14,187	707,122		707,122	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		213,332	213,332	-213,332				113
116	11600	Hospice	816,585	618,352	1,434,937	-162,503	1,272,434	-31,392	1,241,042	116
118		SUBTOTALS (sum of lines 1-117)	16,562,870	17,927,991	34,490,861	-198,414	34,292,447	-3,766,745	30,525,702	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		5,530	5,530	25,878	31,408		31,408	190
194	07950	IROQUOIS WOMEN'S HEALTH	394,299	319,904	714,203	304,905	1,019,108		1,019,108	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	312,750	284,898	597,648	-132,369	465,279		465,279	194.01
200		TOTAL (sum of lines 118-199)	17,269,919	18,538,323	35,808,242		35,808,242	-3,766,745	32,041,497	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS MOVEABLE EQUIP DEPR	A	Cap Rel Costs-Mvble Equip	2		857,593	1
500	Total reclassifications					857,593	500
	Code Letter - A						
1	RECLASS ADVERTISING	B	OTHER ADMINISTRATIVE AND GENE	5.06		94,637	1
2							2
3							3
4							4
5							5
6							6
7							7
500	Total reclassifications					94,637	500
	Code Letter - B						
1	RECLASS MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		657,892	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
500	Total reclassifications					657,892	500
	Code Letter - C						
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Drugs Charged to Patients	73		156,230	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					156,230	500
	Code Letter - D						
1	RECLASS TELEPHONE EXPENSE	E	COMMUNICATIONS	5.04		8,206	1
2			PURCHASING, RECEIVING, AND ST	5.02		147	2
3			Physical Therapy	66		1,123	3
4							4
5							5
6							6
500	Total reclassifications					9,476	500
	Code Letter - E						
1	RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		195,511	1
2			Cap Rel Costs-Mvble Equip	2		17,484	2
3			OTHER ADMINISTRATIVE AND GENE	5.06		337	3
500	Total reclassifications					213,332	500
	Code Letter - F						
1	RECLASS CAFETERIA	G	Cafeteria	11	162,492	151,038	1
500	Total reclassifications				162,492	151,038	500
	Code Letter - G						
1	RECLASS NURSERY COST	H	Nursery	43	214,354	35,328	1
2			Delivery Room & Labor Room	52	147,152	24,253	2
500	Total reclassifications				361,506	59,581	500
	Code Letter - H						
1	RECLASS OPERATION OF PLANT COST	I	Operation of Plant	7		60,610	1
2							2
3							3
4							4
5							5
6							6
7							7

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
8							8
9							9
500	Total reclassifications					60,610	500
	Code Letter - I						
1	RECLASS TRANSPORTATION	J	OTHER ADMINISTRATIVE AND GENE	5.06		26,421	1
2							2
500	Total reclassifications					26,421	500
	Code Letter - J						
1	RECLASS IT COST	K	DATA PROCESSING	5.03		4,634	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
500	Total reclassifications					4,634	500
	Code Letter - K						
1	RECLASS GIFT SHOP	L	Gift, Flower, Coffee Shop & C	190		25,878	1
500	Total reclassifications					25,878	500
	Code Letter - L						
1	RECLASS OTHER CAP RELATED COST	N	Other Cap Rel Costs	3		83,829	1
500	Total reclassifications					83,829	500
	Code Letter - N						
1	RECLASS EMPLOYEE BENEFITS	O	Employee Benefits Department	4		330,816	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					330,816	500
	Code Letter - O						
1	RECLASS IMPL MED SUPPLIES	P	Impl. Dev. Charged to Patient	72		1,049,529	1
2							2
500	Total reclassifications					1,049,529	500
	Code Letter - P						
1	RECLASS BUSINESS OFFICE EXPENSE	Q	BUSINESS OFFICE	5.05		143,724	1
2							2
3							3
4							4
500	Total reclassifications					143,724	500
	Code Letter - Q						
1	TO RECLASS FOR IWH	R	IROQUOIS WOMEN'S HEALTH	194	391,744	123,097	1
500	Total reclassifications				391,744	123,097	500
	Code Letter - R						
	GRAND TOTAL (Increases)				915,742	4,048,317	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS MOVEABLE EQUIP DEPR	A	Cap Rel Costs-Bldg & Fixt	1		857,593	9	1
500	Total reclassifications					857,593		500
	Code letter - A							
1	RECLASS ADVERTISING	B	Rural Health Clinic	88		406		1
2			RHC II	88.01		100		2
3			RHC III	88.02		261		3
4			Home Health Agency	101		1,265		4
5			Hospice	116		3,019		5
6			IROQUOIS WOMEN'S HEALTH	194		3,543		6
7			OTHER NON-REIMBURSABLE COSTS	194.01		86,043		7
500	Total reclassifications					94,637		500
	Code letter - B							
1	RECLASS MEDICAL SUPPLIES	C	PURCHASING, RECEIVING, AND ST	5.02		57,396		1
2			Adults & Pediatrics	30		40,316		2
3			Skilled Nursing Facility	44		18,687		3
4			Operating Room	50		288,051		4
5			Anesthesiology	53		8,384		5
6			Radiology-Diagnostic	54		96,397		6
7			Respiratory Therapy	65		65,738		7
8			Physical Therapy	66		925		8
9			Electrocardiology	69		94		9
10			Clinic	90		81		10
11			Emergency	91		43,343		11
12			Ambulance Services	95		15,303		12
13			Home Health Agency	101		8,099		13
14			Hospice	116		10,462		14
15			IROQUOIS WOMEN'S HEALTH	194		4,616		15
500	Total reclassifications					657,892		500
	Code letter - C							
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Adults & Pediatrics	30		895		1
2			Skilled Nursing Facility	44		2,418		2
3			Operating Room	50		334		3
4			Radiology-Diagnostic	54		4,960		4
5			Laboratory	60		1,169		5
6			Respiratory Therapy	65		27		6
7			Emergency	91		14		7
8			Ambulance Services	95		900		8
9			Home Health Agency	101		657		9
10			Hospice	116		144,856		10
500	Total reclassifications					156,230		500
	Code letter - D							
1	RECLASS TELEPHONE EXPENSE	E	DATA PROCESSING	5.03		498		1
2			OTHER ADMINISTRATIVE AND GENE	5.06		4,897		2
3			Nursing Administration	13		357		3
4			Radiology-Diagnostic	54		741		4
5			OTHER NON-REIMBURSABLE COSTS	194.01		2,819		5
6			Emergency	91		164		6
500	Total reclassifications					9,476		500
	Code letter - E							
1	RECLASS INTEREST EXPENSE	F	Interest Expense	113		213,332	11	1
2							11	2
3							11	3
500	Total reclassifications					213,332		500
	Code letter - F							
1	RECLASS CAFETERIA	G	Dietary	10	162,492	151,038		1
500	Total reclassifications				162,492	151,038		500
	Code letter - G							
1	RECLASS NURSERY COST	H	Adults & Pediatrics	30	361,506	59,581		1
2								2
500	Total reclassifications				361,506	59,581		500
	Code letter - H							
1	RECLASS OPERATION OF PLANT COST	I	Physical Therapy	66		16,809		1
2			Rural Health Clinic	88		5,476		2
3			RHC II	88.01		5,737		3
4			RHC III	88.02		2,133		4
5			Ambulance Services	95		4,547		5
6			Home Health Agency	101		3,566		6

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
7			Hospice	116		3,566		7
8			IROQUOIS WOMEN'S HEALTH	194		16,837		8
9			OTHER NON-REIMBURSABLE COSTS	194.01		1,939		9
500	Total reclassifications					60,610		500
	Code letter - I							
1	RECLASS TRANSPORTATION	J	Ambulance Services	95		20,479		1
2			OTHER NON-REIMBURSABLE COSTS	194.01		5,942		2
500	Total reclassifications					26,421		500
	Code letter - J							
1	RECLASS IT COST	K	Adults & Pediatrics	30		920		1
2			Operating Room	50		1,000		2
3			Radiology-Diagnostic	54		230		3
4			Respiratory Therapy	65		749		4
5			Clinic	90		120		5
6			Emergency	91		415		6
7			Home Health Agency	101		600		7
8			Hospice	116		600		8
500	Total reclassifications					4,634		500
	Code letter - K							
1	RECLASS GIFT SHOP	L	OTHER ADMINISTRATIVE AND GENE	5.06		25,878		1
500	Total reclassifications					25,878		500
	Code letter - L							
1	RECLASS OTHER CAP RELATED COST	N	OTHER ADMINISTRATIVE AND GENE	5.06		83,829	14	1
500	Total reclassifications					83,829		500
	Code letter - N							
1	RECLASS EMPLOYEE BENEFITS	O	Rural Health Clinic	88		38,020		1
2			RHC II	88.01		42,931		2
3			RHC III	88.02		64,410		3
4			Clinic	90		29,464		4
5			IROQUOIS WOMEN'S HEALTH	194		120,365		5
6			OTHER NON-REIMBURSABLE COSTS	194.01		35,626		6
500	Total reclassifications					330,816		500
	Code letter - O							
1	RECLASS IMPL MED SUPPLIES	P	Operating Room	50		769,648		1
2			Radiology-Diagnostic	54		279,881		2
500	Total reclassifications					1,049,529		500
	Code letter - P							
1	RECLASS BUSINESS OFFICE EXPENSE	Q	Rural Health Clinic	88		25,382		1
2			RHC II	88.01		17,290		2
3			RHC III	88.02		36,477		3
4			IROQUOIS WOMEN'S HEALTH	194		64,575		4
500	Total reclassifications					143,724		500
	Code letter - Q							
1	TO RECLASS FOR IWH	R	RHC IV	88.03	391,744	123,097		1
500	Total reclassifications				391,744	123,097		500
	Code letter - R							
	GRAND TOTAL (Decreases)				915,742	4,048,317		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	291,325					291,325		1
2	Land Improvements								2
3	Buildings and Fixtures	25,394,186	161,901		161,901	10,430	25,545,657		3
4	Building Improvements	483,750					483,750		4
5	Fixed Equipment								5
6	Movable Equipment	15,546,819	473,837		473,837	39,912	15,980,744		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	41,716,080	635,738		635,738	50,342	42,301,476		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	41,716,080	635,738		635,738	50,342	42,301,476		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,711,410						1,711,410	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	1,711,410						1,711,410	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	26,320,732		26,320,732	0.622218			52,160	52,160	1
2	Cap Rel Costs-Mvble Equ	15,980,744		15,980,744	0.377782			31,669	31,669	2
3	Total (sum of lines 1-2)	42,301,476		42,301,476	1.000000			83,829	83,829	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	853,817		184,773			52,160	1,090,750	1
2	Cap Rel Costs-Mvble Equip	857,593		16,524			31,669	905,786	2
3	Total (sum of lines 1-2)	1,711,410		201,297			83,829	1,996,536	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-10,738	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)	B	-960	Cap Rel Costs-Mvble Equip	2	11	2
3	Investment income-other (chapter 2)	B	-19	OTHER ADMINISTRATIVE AND GENERAL	5.06		3
4	Trade, quantity, and time discounts (chapter 8)	B	-246	OTHER ADMINISTRATIVE AND GENERAL	5.06		4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)	A	-12,785	Operation of Plant	7		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,877,971				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-155,334	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-91	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-299	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	CNA CLASS REVENUE	B	-393	Nursing Administration	13		33
34							34
35							35
36	AMBULANCE TOWNSHIP INCOME	B	-67,169	Ambulance Services	95		36
37							37
38	RENTAL INCOME	B	-116,761	Clinic	90		38
39	RENTAL INCOME	B	-3,600	Physical Therapy	66		39
40	COLLECTION FEES REVENUE	B	-20,331	ADMISSIONS	5.01		40
41	OTHER REVENUE HSKP	B	-1,523	Housekeeping	9		41
42	OTHER REVENUE-CENTRAL SUPPLY	B	-286	Central Services & Supply	14		42
43	OTHER REVENUE-EDUCATION	B	-79	Ambulance Services	95		43
44							44
45	MISC INCOME A&G	B	-1,302	OTHER ADMINISTRATIVE AND GENERAL	5.06		45
46	MISC INCOME AUXILLIARY	B	-22,737	OTHER ADMINISTRATIVE AND GENERAL	5.06		46
47	MISC INCOME MED STAFF	B	-13,250	OTHER ADMINISTRATIVE AND GENERAL	5.06		47
48	MISC INCOME EMPL COMMITTEE	B	-3,085	OTHER ADMINISTRATIVE AND GENERAL	5.06		48
48.05	NURSE STATION-RH	A	211	Skilled Nursing Facility	44		48.05
48.25	MILFORD-ALLOWANCE	B	-30	RHC II	88.01		48.25
49							49
49.02	PHYSICIAN BENEFIT OFFSET	A	-2,423	Employee Benefits Department	4		49.02
49.03	DONATION EXPENSE	A	-850	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.03
49.04	ALCOHOL EXPENSE	A	-1,985	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.04
49.08	ADVERTISING EXPENSE	A	-87,783	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.08
49.09	PHYSICIAN RECRUITMENT	A	-5,324	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.09
49.11	LOBBYING EXPENSE	A	-100	Hospice	116		49.11
49.12	PROVIDER TAX EXPENSE	A	-1,029,158	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.12
49.13	AMB CABLE COST	A	-603	Ambulance Services	95		49.13
49.14	A&G CABLE TV COST	A	-689	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.14
49.15	HOSPICE PRO FEE	A	-31,292	Hospice	116		49.15
49.21	340B DRUGS	A	-181,288	Drugs Charged to Patients	73		49.21
49.22	340B PURCHASED SERVICES	A	-116,472	Drugs Charged to Patients	73		49.22
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,766,745				50

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	15,003	15,003						1
2	50	Operating Room AGGREGATE	581,858	581,858						2
3	53	Anesthesiology AGGREGATE	651,904	651,904						3
4	54	Radiology-Diagnostic AGGREGATE	48,277	48,277						4
5	65	Respiratory Therapy AGGREGATE	28,660	28,660						5
6	69	Electrocardiology AGGREGATE	14,184	14,184						6
7	90	Clinic AGGREGATE								7
8	91	Emergency AGGREGATE	538,085	538,085						8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,877,971	1,877,971						200

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE							15,003	1
2	50	Operating Room AGGREGATE							581,858	2
3	53	Anesthesiology AGGREGATE							651,904	3
4	54	Radiology-Diagnostic AGGREGATE							48,277	4
5	65	Respiratory Therapy AGGREGATE							28,660	5
6	69	Electrocardiology AGGREGATE							14,184	6
7	90	Clinic AGGREGATE								7
8	91	Emergency AGGREGATE							538,085	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,877,971	200

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,090,750	1,090,750					1
2	Cap Rel Costs-Mvble Equip	905,786		905,786				2
4	Employee Benefits Department	2,086,232	4,694	1,916	2,092,842			4
5.01	ADMISSIONS	531,117	9,220	583	41,897	582,817		5.01
5.02	PURCHASING, RECEIVING, AND STORES	134,189	11,986	377	10,336		156,888	5.02
5.03	DATA PROCESSING	711,831	3,598	61,141	42,643		93	5.03
5.04	COMMUNICATIONS	92,514	2,399		1,394		28	5.04
5.05	BUSINESS OFFICE	365,393	10,739	593	35,010		174	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,638,666	67,592	8,268	113,426		597	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,211,922	106,694	86,353	29,696		2,154	7
8	Laundry & Linen Service	41,474	18,471	137	4,268		169	8
9	Housekeeping	327,549	5,349	154	33,541		1,961	9
10	Dietary	379,257	19,463	2,209	24,095		1,087	10
11	Cafeteria	158,196	8,316		19,937		899	11
12	Maintenance of Personnel							12
13	Nursing Administration	503,446	9,595		47,921		39	13
14	Central Services & Supply	25,672	12,034	5,525	1		1,455	14
15	Pharmacy							15
16	Medical Records & Library	543,358	13,226	278	56,511		82	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,802,831	137,662	61,657	164,870	33,438	3,325	30
43	Nursery	249,732	4,486	599	26,300	1,879		43
44	Skilled Nursing Facility	1,188,831	76,884	39,912	120,903	18,599	2,802	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	952,407	131,346	201,225	83,816	38,603	1,302	50
52	Delivery Room & Labor Room	171,405	1,791		18,055	1,331		52
53	Anesthesiology		928	3,943		1,958	470	53
54	Radiology-Diagnostic	1,126,110	36,623	144,462	85,532	58,961	5,843	54
57	CT Scan	237,398	7,309	100,042	12,934	71,888		57
58	MRI	259,613		460	5,918	16,853		58
60	Laboratory	1,397,514	28,155	11,111	73,773	86,739	21,438	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	477,412	23,845	12,935	51,508	8,944	1,877	65
66	Physical Therapy	769,421	98,857	40,757	77,848	27,855	440	66
69	Electrocardiology	85,617	4,854	6,002	5,583	11,523	14	69
71	Medical Supplies Charged to Patients	657,801				19,778	36,916	71
72	Impl. Dev. Charged to Patients	1,049,529				24,967	58,892	72
73	Drugs Charged to Patients	2,039,909	14,969	7,657	51,005	60,182	310	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	822,454	20,790	908	83,010		387	88
88.01	RHC II	405,310	22,070	17,577	37,724		275	88.01
88.02	RHC III	978,281	33,680	10,765	93,280		551	88.02
88.03	RHC IV	1,203,514	208	13,120	105,340		545	88.03
90	Clinic	22,555	22,206	5,893	33,418	2,388	599	90
91	Emergency	1,061,717	23,709	28,470	109,542	57,521	3,591	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	870,825	1,655	5,989	88,004	39,410	1,095	95
101	Home Health Agency	707,122	10,187	9,247	68,797		579	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	1,241,042	10,251	9,043	100,190		6,070	116
118	SUBTOTALS (sum of lines 1-117)	30,525,702	1,015,841	899,308	1,958,026	582,817	156,059	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	31,408	7,341				52	190
194	IROQUOIS WOMEN'S HEALTH	1,019,108	50,344	6,478	96,443		294	194
194.01	OTHER NON-REIMBURSABLE COSTS	465,279	17,224		38,373		483	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	32,041,497	1,090,750	905,786	2,092,842	582,817	156,888	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING	819,306						5.03
5.04	COMMUNICATIONS		96,335					5.04
5.05	BUSINESS OFFICE	23,568	2,897	438,374				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	25,172	4,587		1,858,308	1,858,308		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	18,885	2,656		1,458,360	89,788	1,548,148	7
8	Laundry & Linen Service	4,026	241		68,786	4,235	32,725	8
9	Housekeeping	33,640	483		402,677	24,792	9,478	9
10	Dietary	21,268	966		448,345	27,604	34,482	10
11	Cafeteria	17,599	1,207		206,154	12,692	14,733	11
12	Maintenance of Personnel							12
13	Nursing Administration	12,156	3,380		576,537	35,496	17,000	13
14	Central Services & Supply				44,687	2,751	21,321	14
15	Pharmacy							15
16	Medical Records & Library	26,405	11,106		650,966	40,079	23,432	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	69,024	19,561	23,696	2,316,064	142,586	243,897	30
43	Nursery	8,107	1,207	1,368	293,678	18,081	7,948	43
44	Skilled Nursing Facility	73,416	2,897	13,125	1,537,369	94,653	136,214	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	27,753	9,416	31,833	1,477,701	90,979	232,704	50
52	Delivery Room & Labor Room	5,565	724	939	199,810	12,302	3,173	52
53	Anesthesiology			1,382	8,681	534	1,643	53
54	Radiology-Diagnostic	34,817	2,897	41,642	1,536,887	94,623	64,884	54
57	CT Scan	4,345	483	50,732	485,131	29,869	12,948	57
58	MRI	2,754	2,173	11,893	299,664	18,450		58
60	Laboratory	37,269	3,380	61,198	1,720,577	105,932	49,881	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	21,343	2,414	6,597	606,875	37,364	42,245	65
66	Physical Therapy	29,184	3,863	19,651	1,067,876	65,747	175,144	66
69	Electrocardiology	2,251	966	8,132	124,942	7,692	8,599	69
71	Medical Supplies Charged to Patients			13,957	728,452	44,849		71
72	Impl. Dev. Charged to Patients			12,156	1,145,544	70,529		72
73	Drugs Charged to Patients	18,208	2,414	42,468	2,237,122	137,735	26,520	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	18,736		4,609	950,894	58,545	36,834	88
88.01	RHC II	11,506		2,792	497,254	30,615	39,100	88.01
88.02	RHC III	27,373		6,574	1,150,504	70,834	59,671	88.02
88.03	RHC IV	33,666		6,048	1,362,441	83,883	368	88.03
90	Clinic	17,474	3,380	1,686	109,599	6,748	39,341	90
91	Emergency	41,931	3,863	41,014	1,371,358	84,432	42,005	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	57,221		27,812	1,092,011	67,233	2,933	95
101	Home Health Agency	24,987			820,919	50,542	18,049	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	39,345	3,380		1,409,321	86,769	18,162	116
118	SUBTOTALS (sum of lines 1-117)	788,994	90,541	431,304	30,265,494	1,748,963	1,415,434	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,345	1,207		41,353	2,546	13,005	190
194	IROQUOIS WOMEN'S HEALTH	9,405		7,070	1,189,142	73,213	89,194	194
194.01	OTHER NON-REIMBURSABLE COSTS	19,562	4,587		545,508	33,586	30,515	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	819,306	96,335	438,374	32,041,497	1,858,308	1,548,148	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	105,746						8
9	Housekeeping	9,778	446,725					9
10	Dietary	779	11,241	522,451				10
11	Cafeteria		4,803		238,382			11
12	Maintenance of Personnel							12
13	Nursing Administration		5,542		5,957	640,532		13
14	Central Services & Supply		6,951				75,710	14
15	Pharmacy							15
16	Medical Records & Library		7,639		12,932			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,358	79,508	98,675	33,820	231,237	2,347	30
43	Nursery	226	2,591		3,971	27,160		43
44	Skilled Nursing Facility	42,945	44,405	385,580	35,973			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,725	75,860	437	13,594	92,975	49,426	50
52	Delivery Room & Labor Room		1,035		2,724	18,643		52
53	Anesthesiology		536					53
54	Radiology-Diagnostic	4,983	21,152		17,056		1,879	54
57	CT Scan		4,221		2,126			57
58	MRI				1,349			58
60	Laboratory	159	16,261		18,253			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		13,772		10,450	71,502	370	65
66	Physical Therapy	5,304	57,096		14,294			66
69	Electrocardiology		2,803		1,107			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		8,645		8,923			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic						1,434	88
88.01	RHC II						362	88.01
88.02	RHC III						641	88.02
88.03	RHC IV	15	120					88.03
90	Clinic	2,472	12,825	874	8,566	58,542	445	90
91	Emergency	14,459	13,693	5,439	20,544	140,473	1,607	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	543	956					95
101	Home Health Agency		5,884					101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		5,921					116
118	SUBTOTALS (sum of lines 1-117)	105,746	403,460	491,005	211,639	640,532	58,511	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,240		662			190
194	IROQUOIS WOMEN'S HEALTH		29,077		16,496		17,199	194
194.01	OTHER NON-REIMBURSABLE COSTS		9,948	31,446	9,585			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	105,746	446,725	522,451	238,382	640,532	75,710	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	735,048						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	47,031	3,209,523		3,209,523			30
43	Nursery	2,716	356,371		356,371			43
44	Skilled Nursing Facility		2,277,139		2,277,139			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	63,181	2,106,582		2,106,582			50
52	Delivery Room & Labor Room	1,865	239,552		239,552			52
53	Anesthesiology	2,743	14,137		14,137			53
54	Radiology-Diagnostic	82,649	1,824,113		1,824,113			54
57	CT Scan	100,691	634,986		634,986			57
58	MRI	23,605	343,068		343,068			58
60	Laboratory	121,467	2,032,530		2,032,530			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,094	795,672		795,672			65
66	Physical Therapy	39,003	1,424,464		1,424,464			66
69	Electrocardiology	16,139	161,282		161,282			69
71	Medical Supplies Charged to Patients	27,701	801,002		801,002			71
72	Impl. Dev. Charged to Patients	24,127	1,240,200		1,240,200			72
73	Drugs Charged to Patients	84,288	2,503,233		2,503,233			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		1,047,707		1,047,707			88
88.01	RHC II		567,331		567,331			88.01
88.02	RHC III		1,281,650		1,281,650			88.02
88.03	RHC IV		1,446,827		1,446,827			88.03
90	Clinic	3,346	242,758		242,758			90
91	Emergency	81,402	1,775,412		1,775,412			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		1,163,676		1,163,676			95
101	Home Health Agency		895,394		895,394			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		1,520,173		1,520,173			116
118	SUBTOTALS (sum of lines 1-117)	735,048	29,904,782		29,904,782			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		61,806		61,806			190
194	IROQUOIS WOMEN'S HEALTH		1,414,321		1,414,321			194
194.01	OTHER NON-REIMBURSABLE COSTS		660,588		660,588			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	735,048	32,041,497		32,041,497			202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	2,012	4,694	1,916	8,622	8,622		4
5.01	ADMISSIONS	7,854	9,220	583	17,657	172	17,829	5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,185	11,986	377	13,548	43		5.02
5.03	DATA PROCESSING	2,404	3,598	61,141	67,143	176		5.03
5.04	COMMUNICATIONS		2,399		2,399	6		5.04
5.05	BUSINESS OFFICE		10,739	593	11,332	144		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,184	67,592	8,268	77,044	467		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	720	106,694	86,353	193,767	122		7
8	Laundry & Linen Service		18,471	137	18,608	18		8
9	Housekeeping		5,349	154	5,503	138		9
10	Dietary	2,149	19,463	2,209	23,821	99		10
11	Cafeteria	1,778	8,316		10,094	82		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,175	9,595		15,770	197		13
14	Central Services & Supply		12,034	5,525	17,559			14
15	Pharmacy							15
16	Medical Records & Library	3,483	13,226	278	16,987	233		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,971	137,662	61,657	206,290	686	1,022	30
43	Nursery		4,486	599	5,085	108	57	43
44	Skilled Nursing Facility	7,526	76,884	39,912	124,322	498	569	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,973	131,346	201,225	341,544	345	1,180	50
52	Delivery Room & Labor Room		1,791		1,791	74	41	52
53	Anesthesiology		928	3,943	4,871		60	53
54	Radiology-Diagnostic	42,924	36,623	144,462	224,009	352	1,803	54
57	CT Scan		7,309	100,042	107,351	53	2,198	57
58	MRI			460	460	24	515	58
60	Laboratory	15,974	28,155	11,111	55,240	304	2,662	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,633	23,845	12,935	42,413	212	273	65
66	Physical Therapy	4,384	98,857	40,757	143,998	320	852	66
69	Electrocardiology	343	4,854	6,002	11,199	23	352	69
71	Medical Supplies Charged to Patients						605	71
72	Impl. Dev. Charged to Patients						763	72
73	Drugs Charged to Patients	2,415	14,969	7,657	25,041	210	1,840	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,637	20,790	908	25,335	342		88
88.01	RHC II	1,941	22,070	17,577	41,588	155		88.01
88.02	RHC III	3,875	33,680	10,765	48,320	384		88.02
88.03	RHC IV	5,564	208	13,120	18,892	434		88.03
90	Clinic	1,868	22,206	5,893	29,967	138	73	90
91	Emergency	2,332	23,709	28,470	54,511	451	1,759	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	27,154	1,655	5,989	34,798	362	1,205	95
101	Home Health Agency	5,880	10,187	9,247	25,314	283		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	99,860	10,251	9,043	119,154	412		116
118	SUBTOTALS (sum of lines 1-117)	276,198	1,015,841	899,308	2,191,347	8,067	17,829	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		7,341		7,341			190
194	IROQUOIS WOMEN'S HEALTH	30,466	50,344	6,478	87,288	397		194
194.01	OTHER NON-REIMBURSABLE COSTS		17,224		17,224	158		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	306,664	1,090,750	905,786	2,303,200	8,622	17,829	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES	13,591						5.02
5.03	DATA PROCESSING	8	67,327					5.03
5.04	COMMUNICATIONS	2		2,407				5.04
5.05	BUSINESS OFFICE	15	1,937	72	13,500			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	52	2,069	115		79,747		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	187	1,552	66		3,853	199,547	7
8	Laundry & Linen Service	15	331	6		182	4,218	8
9	Housekeeping	170	2,764	12		1,064	1,222	9
10	Dietary	94	1,748	24		1,185	4,445	10
11	Cafeteria	78	1,446	30		545	1,899	11
12	Maintenance of Personnel							12
13	Nursing Administration	3	999	84		1,523	2,191	13
14	Central Services & Supply	126				118	2,748	14
15	Pharmacy							15
16	Medical Records & Library	7	2,170	277		1,720	3,020	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	288	5,672	493	730	6,120	31,439	30
43	Nursery		666	30	42	776	1,024	43
44	Skilled Nursing Facility	243	6,032	72	405	4,062	17,557	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	113	2,281	235	981	3,904	29,994	50
52	Delivery Room & Labor Room		457	18	29	528	409	52
53	Anesthesiology	41			43	23	212	53
54	Radiology-Diagnostic	506	2,861	72	1,284	4,060	8,363	54
57	CT Scan		357	12	1,564	1,282	1,669	57
58	MRI		226	54	367	792		58
60	Laboratory	1,857	3,063	84	1,873	4,546	6,429	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	163	1,754	60	203	1,603	5,445	65
66	Physical Therapy	38	2,398	97	606	2,821	22,575	66
69	Electrocardiology	1	185	24	251	330	1,108	69
71	Medical Supplies Charged to Patients	3,198			430	1,925		71
72	Impl. Dev. Charged to Patients	5,100			375	3,027		72
73	Drugs Charged to Patients	27	1,496	60	1,309	5,910	3,418	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	34	1,540		142	2,512	4,748	88
88.01	RHC II	24	946		86	1,314	5,040	88.01
88.02	RHC III	48	2,249		203	3,040	7,691	88.02
88.03	RHC IV	47	2,767		186	3,600	47	88.03
90	Clinic	52	1,436	84	52	290	5,071	90
91	Emergency	311	3,446	97	1,264	3,623	5,414	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	95	4,702		857	2,885	378	95
101	Home Health Agency	50	2,053			2,169	2,326	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	526	3,233	84		3,723	2,341	116
118	SUBTOTALS (sum of lines 1-117)	13,519	64,836	2,262	13,282	75,055	182,441	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5	111	30		109	1,676	190
194	IROQUOIS WOMEN'S HEALTH	25	773		218	3,142	11,497	194
194.01	OTHER NON-REIMBURSABLE COSTS	42	1,607	115		1,441	3,933	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,591	67,327	2,407	13,500	79,747	199,547	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	23,378						8
9	Housekeeping	2,162	13,035					9
10	Dietary	172	328	31,916				10
11	Cafeteria		140		14,314			11
12	Maintenance of Personnel							12
13	Nursing Administration		162		358	21,287		13
14	Central Services & Supply		203				20,754	14
15	Pharmacy							15
16	Medical Records & Library		223		777			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,174	2,318	6,028	2,031	7,684	643	30
43	Nursery	50	76		238	903		43
44	Skilled Nursing Facility	9,493	1,296	23,555	2,159			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,150	2,214	27	816	3,090	13,549	50
52	Delivery Room & Labor Room		30		164	620		52
53	Anesthesiology		16					53
54	Radiology-Diagnostic	1,102	617		1,024		515	54
57	CT Scan		123		128			57
58	MRI				81			58
60	Laboratory	35	474		1,096			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		402		627	2,376	101	65
66	Physical Therapy	1,173	1,666		858			66
69	Electrocardiology		82		66			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		252		536			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic						393	88
88.01	RHC II						99	88.01
88.02	RHC III						176	88.02
88.03	RHC IV	3	4					88.03
90	Clinic	547	374	53	514	1,946	122	90
91	Emergency	3,197	400	332	1,234	4,668	441	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	120	28					95
101	Home Health Agency		172					101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		173					116
118	SUBTOTALS (sum of lines 1-117)	23,378	11,773	29,995	12,707	21,287	16,039	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		124		40			190
194	IROQUOIS WOMEN'S HEALTH		848		991		4,715	194
194.01	OTHER NON-REIMBURSABLE COSTS		290	1,921	576			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,378	13,035	31,916	14,314	21,287	20,754	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	25,414						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,627	276,245		276,245			30
43	Nursery	94	9,149		9,149			43
44	Skilled Nursing Facility		190,263		190,263			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,186	404,609		404,609			50
52	Delivery Room & Labor Room	65	4,226		4,226			52
53	Anesthesiology	95	5,361		5,361			53
54	Radiology-Diagnostic	2,860	249,428		249,428			54
57	CT Scan	3,484	118,221		118,221			57
58	MRI	817	3,336		3,336			58
60	Laboratory	4,181	81,844		81,844			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	453	56,085		56,085			65
66	Physical Therapy	1,350	178,752		178,752			66
69	Electrocardiology	558	14,179		14,179			69
71	Medical Supplies Charged to Patients	959	7,117		7,117			71
72	Impl. Dev. Charged to Patients	835	10,100		10,100			72
73	Drugs Charged to Patients	2,917	43,016		43,016			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		35,046		35,046			88
88.01	RHC II		49,252		49,252			88.01
88.02	RHC III		62,111		62,111			88.02
88.03	RHC IV		25,980		25,980			88.03
90	Clinic	116	40,835		40,835			90
91	Emergency	2,817	83,965		83,965			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		45,430		45,430			95
101	Home Health Agency		32,367		32,367			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		129,646		129,646			116
118	SUBTOTALS (sum of lines 1-117)	25,414	2,156,563		2,156,563			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		9,436		9,436			190
194	IROQUOIS WOMEN'S HEALTH		109,894		109,894			194
194.01	OTHER NON-REIMBURSABLE COSTS		27,307		27,307			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,414	2,303,200		2,303,200			202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	136,408						1
2	Cap Rel Costs-Mvble Equip		1,527,571					2
4	Employee Benefits Department	587	3,232	17,057,451				4
5.01	ADMISSIONS	1,153	983	341,477	70,438,380			5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,499	636	84,239		2,795,953		5.02
5.03	DATA PROCESSING	450	103,112	347,557		1,664	655,886	5.03
5.04	COMMUNICATIONS	300		11,360		500		5.04
5.05	BUSINESS OFFICE	1,343	1,000	285,341		3,102	18,867	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	8,453	13,943	924,461		10,644	20,151	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	13,343	145,631	242,030		38,380	15,118	7
8	Laundry & Linen Service	2,310	231	34,786		3,009	3,223	8
9	Housekeeping	669	259	273,370		34,945	26,930	9
10	Dietary	2,434	3,726	196,379		19,368	17,026	10
11	Cafeteria	1,040		162,492		16,027	14,089	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,200		390,573		694	9,731	13
14	Central Services & Supply	1,505	9,318	10		25,931		14
15	Pharmacy							15
16	Medical Records & Library	1,654	469	460,582		1,458	21,138	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,216	103,982	1,343,825	4,041,311	59,249	55,256	30
43	Nursery	561	1,011	214,354	227,044		6,490	43
44	Skilled Nursing Facility	9,615	67,310	985,404	2,247,854	49,936	58,774	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,426	339,354	683,131	4,665,537	23,197	22,217	50
52	Delivery Room & Labor Room	224		147,152	160,894		4,455	52
53	Anesthesiology	116	6,649		236,673	8,384		53
54	Radiology-Diagnostic	4,580	243,629	697,119	7,126,004	104,134	27,872	54
57	CT Scan	914	168,716	105,417	8,688,478		3,478	57
58	MRI		775	48,230	2,036,820		2,205	58
60	Laboratory	3,521	18,739	601,277	10,482,315	382,057	29,835	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,982	21,815	419,809	1,081,024	33,445	17,086	65
66	Physical Therapy	12,363	68,735	634,488	3,366,574	7,848	23,363	66
69	Electrocardiology	607	10,122	45,500	1,392,634	247	1,802	69
71	Medical Supplies Charged to Patients				2,390,325	657,892		71
72	Impl. Dev. Charged to Patients				3,017,541	1,049,529		72
73	Drugs Charged to Patients	1,872	12,914	415,706	7,273,667	5,531	14,576	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,600	1,532	676,565		6,904	14,999	88
88.01	RHC II	2,760	29,643	307,461		4,892	9,211	88.01
88.02	RHC III	4,212	18,155	760,263		9,826	21,913	88.02
88.03	RHC IV	26	22,126	858,557		9,711	26,951	88.03
90	Clinic	2,777	9,939	272,370	288,588	10,671	13,989	90
91	Emergency	2,965	48,014	892,803	6,951,992	64,000	33,567	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	207	10,101	717,262	4,763,105	19,522	45,808	95
101	Home Health Agency	1,274	15,594	560,723		10,324	20,003	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,282	15,251	816,585		108,167	31,497	116
118	SUBTOTALS (sum of lines 1-117)	127,040	1,516,646	15,958,658	70,438,380	2,781,188	631,620	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	918				932	1,077	190
194	IROQUOIS WOMEN'S HEALTH	6,296	10,925	786,043		5,233	7,529	194
194.01	OTHER NON-REIMBURSABLE COSTS	2,154		312,750		8,600	15,660	194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,090,750	905,786	2,092,842	582,817	156,888	819,306	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.996232	0.592958	0.122694	0.008274	0.056113	1.249159	203
204	Cost to be allocated (Per Wkst. B, Part II)			8,622	17,829	13,591	67,327	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000505	0.000253	0.004861	0.102650	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	COMMUNICATIONS # OF PHONES	BUSINESS OFFICE GROSS CHARGES	RECON-CILIATION	OTHER ADMINISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS	399						5.04
5.05	BUSINESS OFFICE	12	75,078,366					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	19		-1,858,308	30,183,189			5.06
6	Maintenance & Repairs							6
7	Operation of Plant	11			1,458,360	109,280		7
8	Laundry & Linen Service	1			68,786	2,310	276,305	8
9	Housekeeping	2			402,677	669	25,550	9
10	Dietary	4			448,345	2,434	2,035	10
11	Cafeteria	5			206,154	1,040		11
12	Maintenance of Personnel							12
13	Nursing Administration	14			576,537	1,200		13
14	Central Services & Supply				44,687	1,505		14
15	Pharmacy							15
16	Medical Records & Library	46			650,966	1,654		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	81	4,058,228		2,316,064	17,216	37,515	30
43	Nursery	5	234,371		293,678	561	590	43
44	Skilled Nursing Facility	12	2,247,854		1,537,369	9,615	112,210	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	39	5,451,838		1,477,701	16,426	25,410	50
52	Delivery Room & Labor Room	3	160,894		199,810	224		52
53	Anesthesiology		236,673		8,681	116		53
54	Radiology-Diagnostic	12	7,131,636		1,536,887	4,580	13,020	54
57	CT Scan	2	8,688,478		485,131	914		57
58	MRI	9	2,036,820		299,664			58
60	Laboratory	14	10,482,315		1,720,577	3,521	415	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10	1,129,886		606,875	2,982		65
66	Physical Therapy	16	3,365,550		1,067,876	12,363	13,860	66
69	Electrocardiology	4	1,392,634		124,942	607		69
71	Medical Supplies Charged to Patients		2,390,325		728,452			71
72	Impl. Dev. Charged to Patients		2,081,883		1,145,544			72
73	Drugs Charged to Patients	10	7,273,095		2,237,122	1,872		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		789,263		950,894	2,600		88
88.01	RHC II		478,207		497,254	2,760		88.01
88.02	RHC III		1,125,930		1,150,504	4,212		88.02
88.03	RHC IV		1,035,772		1,362,441	26	40	88.03
90	Clinic	14	288,701		109,599	2,777	6,460	90
91	Emergency	16	7,024,094		1,371,358	2,965	37,780	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		4,763,105		1,092,011	207	1,420	95
101	Home Health Agency				820,919	1,274		101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	14			1,409,321	1,282		116
118	SUBTOTALS (sum of lines 1-117)	375	73,867,552	-1,858,308	28,407,186	99,912	276,305	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5			41,353	918		190
194	IROQUOIS WOMEN'S HEALTH		1,210,814		1,189,142	6,296		194
194.01	OTHER NON-REIMBURSABLE COSTS	19			545,508	2,154		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	96,335	438,374		1,858,308	1,548,148	105,746	202
203	Unit Cost Multiplier (Wkst. B, Part I)	241.441103	0.005839		0.061568	14.166801	0.382715	203
204	Cost to be allocated (Per Wkst. B, Part II)	2,407	13,500		79,747	199,547	23,378	204
205	Unit Cost Multiplier (Wkst. B, Part II)	6.032581	0.000180		0.002642	1.826016	0.084609	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINIS-TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	14	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	96,729						9
10	Dietary	2,434	47,832					10
11	Cafeteria	1,040		18,728				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,200		468	153,060			13
14	Central Services & Supply	1,505				10,032		14
15	Pharmacy							15
16	Medical Records & Library	1,654		1,016			63,427,421	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,216	9,034	2,657	55,256	311	4,058,228	30
43	Nursery	561		312	6,490		234,371	43
44	Skilled Nursing Facility	9,615	35,301	2,826				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,426	40	1,068	22,217	6,549	5,451,838	50
52	Delivery Room & Labor Room	224		214	4,455		160,894	52
53	Anesthesiology	116					236,673	53
54	Radiology-Diagnostic	4,580		1,340		249	7,131,636	54
57	CT Scan	914		167			8,688,478	57
58	MRI			106			2,036,820	58
60	Laboratory	3,521		1,434			10,482,315	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,982		821	17,086	49	1,129,886	65
66	Physical Therapy	12,363		1,123			3,365,550	66
69	Electrocardiology	607		87			1,392,634	69
71	Medical Supplies Charged to Patients						2,390,325	71
72	Impl. Dev. Charged to Patients						2,081,883	72
73	Drugs Charged to Patients	1,872		701			7,273,095	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					190		88
88.01	RHC II					48		88.01
88.02	RHC III					85		88.02
88.03	RHC IV	26						88.03
90	Clinic	2,777	80	673	13,989	59	288,701	90
91	Emergency	2,965	498	1,614	33,567	213	7,024,094	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	207						95
101	Home Health Agency	1,274						101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,282						116
118	SUBTOTALS (sum of lines 1-117)	87,361	44,953	16,627	153,060	7,753	63,427,421	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	918		52				190
194	IROQUOIS WOMEN'S HEALTH	6,296		1,296		2,279		194
194.01	OTHER NON-REIMBURSABLE COSTS	2,154	2,879	753				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	446,725	522,451	238,382	640,532	75,710	735,048	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.618315	10.922625	12.728642	4.184843	7.546850	0.011589	203
204	Cost to be allocated (Per Wkst. B, Part II)	13,035	31,916	14,314	21,287	20,754	25,414	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.134758	0.667252	0.764310	0.139076	2.068780	0.000401	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	IROQUOIS WOMEN'S HEALTH							194
194.01	OTHER NON-REIMBURSABLE COSTS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							
205	Unit Cost Multiplier (Wkst. B, Part II)							205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,209,523		3,209,523		3,209,523	30
43	Nursery	356,371		356,371		356,371	43
44	Skilled Nursing Facility	2,277,139		2,277,139		2,277,139	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,106,582		2,106,582		2,106,582	50
52	Delivery Room & Labor Room	239,552		239,552		239,552	52
53	Anesthesiology	14,137		14,137		14,137	53
54	Radiology-Diagnostic	1,824,113		1,824,113		1,824,113	54
57	CT Scan	634,986		634,986		634,986	57
58	MRI	343,068		343,068		343,068	58
60	Laboratory	2,032,530		2,032,530		2,032,530	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	795,672		795,672		795,672	65
66	Physical Therapy	1,424,464		1,424,464		1,424,464	66
69	Electrocardiology	161,282		161,282		161,282	69
71	Medical Supplies Charged to Patients	801,002		801,002		801,002	71
72	Impl. Dev. Charged to Patients	1,240,200		1,240,200		1,240,200	72
73	Drugs Charged to Patients	2,503,233		2,503,233		2,503,233	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	1,047,707		1,047,707		1,047,707	88
88.01	RHC II	567,331		567,331		567,331	88.01
88.02	RHC III	1,281,650		1,281,650		1,281,650	88.02
88.03	RHC IV	1,446,827		1,446,827		1,446,827	88.03
90	Clinic	242,758		242,758		242,758	90
91	Emergency	1,775,412		1,775,412		1,775,412	91
92	Observation Beds (Non-Distinct Part)	845,919		845,919		845,919	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,163,676		1,163,676		1,163,676	95
101	Home Health Agency	895,394		895,394		895,394	101
113	Interest Expense						113
116	Hospice	1,520,173		1,520,173		1,520,173	116
200	Subtotal (sum of lines 30 thru 199)	30,750,701		30,750,701		30,750,701	200
201	Less Observation Beds	845,919		845,919		845,919	201
202	Total (line 200 minus line 201)	29,904,782		29,904,782		29,904,782	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	2,833,008		2,833,008				30
43	Nursery	227,044		227,044				43
44	Skilled Nursing Facility	2,247,854		2,247,854				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,079,031	3,586,506	4,665,537	0.451520	0.451520	0.451520	50
52	Delivery Room & Labor Room	155,405	5,489	160,894	1.488881	1.488881	1.488881	52
53	Anesthesiology	79,787	156,886	236,673	0.059732	0.059732	0.059732	53
54	Radiology-Diagnostic	496,199	6,629,805	7,126,004	0.255980	0.255980	0.255980	54
57	CT Scan	701,882	7,986,596	8,688,478	0.073084	0.073084	0.073084	57
58	MRI	13,690	2,023,130	2,036,820	0.168433	0.168433	0.168433	58
60	Laboratory	1,064,890	9,417,425	10,482,315	0.193901	0.193901	0.193901	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	341,475	739,549	1,081,024	0.736035	0.736035	0.736035	65
66	Physical Therapy	808,163	2,558,411	3,366,574	0.423120	0.423120	0.423120	66
69	Electrocardiology	645,354	747,280	1,392,634	0.115811	0.115811	0.115811	69
71	Medical Supplies Charged to Patients	1,120,820	1,269,505	2,390,325	0.335102	0.335102	0.335102	71
72	Impl. Dev. Charged to Patients	1,214,213	1,803,328	3,017,541	0.410997	0.410997	0.410997	72
73	Drugs Charged to Patients	2,077,682	5,195,985	7,273,667	0.344150	0.344150	0.344150	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		789,263	789,263				88
88.01	RHC II		478,207	478,207				88.01
88.02	RHC III		1,125,930	1,125,930				88.02
88.03	RHC IV		1,035,772	1,035,772				88.03
90	Clinic	599	287,989	288,588	0.841192	0.841192	0.841192	90
91	Emergency	510,361	6,441,631	6,951,992	0.255382	0.255382	0.255382	91
92	Observation Beds (Non-Distinct Part)	257,864	950,439	1,208,303	0.700088	0.700088	0.700088	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,983	4,758,122	4,763,105	0.244310	0.244310	0.244310	95
101	Home Health Agency		756,271	756,271				101
113	Interest Expense							113
116	Hospice		1,513,172	1,513,172				116
200	Subtotal (sum of lines 30 thru 199)	15,880,304	60,256,691	76,136,995				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	15,880,304	60,256,691	76,136,995				202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[XX] Title XVIII, Part A
[ ] Title XIX
[XX] PPS
[ ] TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	276,245		276,245	2,322	118.97	1,064	126,584	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	9,149		9,149	138	66.30			43
44	Skilled Nursing Facility	190,263		190,263	11,312	16.82	1,685	28,342	44
45	Nursing Facility								45
200	Total (lines 30-199)	475,657		475,657	13,772		2,749	154,926	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0167** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[ ] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other)
[XX] PPS **[ ] TEFRA**

(A)	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 (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	404,609	4,665,537	0.086723	849,498	73,671	50
52	Delivery Room & Labor Room	4,226	160,894	0.026266	818	21	52
53	Anesthesiology	5,361	236,673	0.022652	37,681	854	53
54	Radiology-Diagnostic	249,428	7,126,004	0.035003	431,265	15,096	54
57	CT Scan	118,221	8,688,478	0.013607	650,653	8,853	57
58	MRI	3,336	2,036,820	0.001638	11,408	19	58
60	Laboratory	81,844	10,482,315	0.007808	907,653	7,087	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	56,085	1,081,024	0.051881	315,120	16,349	65
66	Physical Therapy	178,752	3,366,574	0.053096	110,949	5,891	66
69	Electrocardiology	14,179	1,392,634	0.010181	255,449	2,601	69
71	Medical Supplies Charged to Pat	7,117	2,390,325	0.002977	246,617	734	71
72	Impl. Dev. Charged to Patients	10,100	3,017,541	0.003347	522,946	1,750	72
73	Drugs Charged to Patients	43,016	7,273,667	0.005914	1,273,934	7,534	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	35,046	789,263	0.044403			88
88.01	RHC II	49,252	478,207	0.102993			88.01
88.02	RHC III	62,111	1,125,930	0.055164			88.02
88.03	RHC IV	25,980	1,035,772	0.025083			88.03
90	Clinic	40,835	288,588	0.141499			90
91	Emergency	83,965	6,951,992	0.012078	356,085	4,301	91
92	Observation Beds (Non-Distinct	72,808	1,208,303	0.060256	181,762	10,952	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,546,271	63,796,541		6,151,838	155,713	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V **[XX] PPS**
[XX] Title XVIII, Part A **[ ] TEFRA**
[ ] Title XIX **[ ] Other**

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,322		1,064		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	138				43
44	Skilled Nursing Facility	11,312		1,685		44
45	Nursing Facility					45
200	Total (lines 30-199)	13,772		2,749		200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0167** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V; [XX] Title XVIII, Part A; [ ] Title XIX; [XX] Hospital; [ ] IPF; [ ] IRF; [ ] SUB (Other); [ ] SNF; [ ] NF; [ ] ICF/IID; [XX] PPS; [ ] TEFRA; [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0167** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		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	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	4,665,537			849,498		1,893,268		50
52	Delivery Room & Labor Room	160,894			818				52
53	Anesthesiology	236,673			37,681		37,589		53
54	Radiology-Diagnostic	7,126,004			431,265		2,857,451		54
57	CT Scan	8,688,478			650,653		3,507,903		57
58	MRI	2,036,820			11,408		653,136		58
60	Laboratory	10,482,315			907,653		1,772,509		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,081,024			315,120		361,849		65
66	Physical Therapy	3,366,574			110,949		7,065		66
69	Electrocardiology	1,392,634			255,449		530,761		69
71	Medical Supplies Charged to Pat	2,390,325			246,617		217,245		71
72	Impl. Dev. Charged to Patients	3,017,541			522,946		858,906		72
73	Drugs Charged to Patients	7,273,667			1,273,934		3,037,243		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	789,263							88
88.01	RHC II	478,207							88.01
88.02	RHC III	1,125,930							88.02
88.03	RHC IV	1,035,772							88.03
90	Clinic	288,588					7,167		90
91	Emergency	6,951,992			356,085		1,944,422		91
92	Observation Beds (Non-Distinct	1,208,303			181,762		608,862		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	63,796,541			6,151,838		18,295,376		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0167** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.451520	1,893,268			854,848			50
52	Delivery Room & Labor Room	1.488881							52
53	Anesthesiology	0.059732	37,589			2,245			53
54	Radiology-Diagnostic	0.255980	2,857,451			731,450			54
57	CT Scan	0.073084	3,507,903			256,372			57
58	MRI	0.168433	653,136			110,010			58
60	Laboratory	0.193901	1,772,509			343,691			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.736035	361,849			266,334			65
66	Physical Therapy	0.423120	7,065			2,989			66
69	Electrocardiology	0.115811	530,761			61,468			69
71	Medical Supplies Charged to Pat	0.335102	217,245			72,799			71
72	Impl. Dev. Charged to Patients	0.410997	858,906			353,008			72
73	Drugs Charged to Patients	0.344150	3,037,243			1,045,267			73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic	0.841192	7,167			6,029			90
91	Emergency	0.255382	1,944,422			496,570			91
92	Observation Beds (Non-Distinct	0.700088	608,862			426,257			92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.244310							95
200	Subtotal (see instructions)		18,295,376			5,029,337			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		18,295,376			5,029,337			202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-U167** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.451520							50
52	Delivery Room & Labor Room	1.488881							52
53	Anesthesiology	0.059732							53
54	Radiology-Diagnostic	0.255980							54
57	CT Scan	0.073084							57
58	MRI	0.168433							58
60	Laboratory	0.193901							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.736035							65
66	Physical Therapy	0.423120							66
69	Electrocardiology	0.115811							69
71	Medical Supplies Charged to Pat	0.335102							71
72	Impl. Dev. Charged to Patients	0.410997							72
73	Drugs Charged to Patients	0.344150							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic	0.841192							90
91	Emergency	0.255382							91
92	Observation Beds (Non-Distinct	0.700088							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.244310							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-6049** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V | [ ] Hospital | [ ] SUB (Other) | [ ] ICF/IID | [XX] PPS
[XX] Title XVIII, Part A | [ ] IPF | [XX] SNF | [ ] TEFRA
[ ] Title XIX | [ ] IRF | [ ] NF | [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-6049** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [XX] SNF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] Other

		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	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	4,665,537							50
52	Delivery Room & Labor Room	160,894							52
53	Anesthesiology	236,673							53
54	Radiology-Diagnostic	7,126,004			13,902				54
57	CT Scan	8,688,478							57
58	MRI	2,036,820							58
60	Laboratory	10,482,315			36,178				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,081,024			61				65
66	Physical Therapy	3,366,574			617,200				66
69	Electrocardiology	1,392,634			170				69
71	Medical Supplies Charged to Pat	2,390,325			7,713				71
72	Impl. Dev. Charged to Patients	3,017,541							72
73	Drugs Charged to Patients	7,273,667			72,187				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	789,263							88
88.01	RHC II	478,207							88.01
88.02	RHC III	1,125,930							88.02
88.03	RHC IV	1,035,772							88.03
90	Clinic	288,588							90
91	Emergency	6,951,992							91
92	Observation Beds (Non-Distinct	1,208,303							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	63,796,541			747,411				200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-6049** **WORKSHEET D PART V**

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[XX] Title XVIII, Part B	[ ] IPF	[XX] SNF	[ ] Swing Bed NF
[ ] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.451520							50
52	Delivery Room & Labor Room	1.488881							52
53	Anesthesiology	0.059732							53
54	Radiology-Diagnostic	0.255980							54
57	CT Scan	0.073084							57
58	MRI	0.168433							58
60	Laboratory	0.193901							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.736035							65
66	Physical Therapy	0.423120							66
69	Electrocardiology	0.115811							69
71	Medical Supplies Charged to Pat	0.335102							71
72	Impl. Dev. Charged to Patients	0.410997							72
73	Drugs Charged to Patients	0.344150							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic	0.841192							90
91	Emergency	0.255382							91
92	Observation Beds (Non-Distinct	0.700088							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.244310							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[XX] PPS** **[ ] TEFRA**

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	276,245		276,245	2,322	118.97	218	25,935	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	9,149		9,149	138	66.30	100	6,630	43
44	Skilled Nursing Facility	190,263		190,263	11,312	16.82			44
45	Nursing Facility								45
200	Total (lines 30-199)	475,657		475,657	13,772		318	32,565	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0167** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA**

(A)	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 (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	404,609	4,665,537	0.086723	203,450	17,644	50
52	Delivery Room & Labor Room	4,226	160,894	0.026266	47,312	1,243	52
53	Anesthesiology	5,361	236,673	0.022652	11,263	255	53
54	Radiology-Diagnostic	249,428	7,126,004	0.035003	43,754	1,532	54
57	CT Scan	118,221	8,688,478	0.013607	42,652	580	57
58	MRI	3,336	2,036,820	0.001638			58
60	Laboratory	81,844	10,482,315	0.007808	112,724	880	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	56,085	1,081,024	0.051881	26,110	1,355	65
66	Physical Therapy	178,752	3,366,574	0.053096	8,529	453	66
69	Electrocardiology	14,179	1,392,634	0.010181	7,801	79	69
71	Medical Supplies Charged to Pat	7,117	2,390,325	0.002977	32,160	96	71
72	Impl. Dev. Charged to Patients	10,100	3,017,541	0.003347	59,537	199	72
73	Drugs Charged to Patients	43,016	7,273,667	0.005914	160,768	951	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	35,046	789,263	0.044403			88
88.01	RHC II	49,252	478,207	0.102993			88.01
88.02	RHC III	62,111	1,125,930	0.055164			88.02
88.03	RHC IV	25,980	1,035,772	0.025083			88.03
90	Clinic	40,835	288,588	0.141499			90
91	Emergency	83,965	6,951,992	0.012078	6,432	78	91
92	Observation Beds (Non-Distinct	72,808	1,208,303	0.060256			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,546,271	63,796,541		762,492	25,345	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V **[XX] PPS**
[ ] Title XVIII, Part A **[ ] TEFRA**
[XX] Title XIX **[ ] Other**

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,322		218		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	138		100		43
44	Skilled Nursing Facility	11,312				44
45	Nursing Facility					45
200	Total (lines 30-199)	13,772		318		200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0167** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V; [XX] Title XVIII, Part A; [XX] Title XIX; [XX] Hospital; [ ] IPF; [ ] IRF; [ ] SUB (Other); [ ] SNF; [ ] NF; [ ] ICF/IID; [XX] PPS; [ ] TEFRA; [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0167** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		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	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	4,665,537			203,450				50
52	Delivery Room & Labor Room	160,894			47,312				52
53	Anesthesiology	236,673			11,263				53
54	Radiology-Diagnostic	7,126,004			43,754				54
57	CT Scan	8,688,478			42,652				57
58	MRI	2,036,820							58
60	Laboratory	10,482,315			112,724				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,081,024			26,110				65
66	Physical Therapy	3,366,574			8,529				66
69	Electrocardiology	1,392,634			7,801				69
71	Medical Supplies Charged to Pat	2,390,325			32,160				71
72	Impl. Dev. Charged to Patients	3,017,541			59,537				72
73	Drugs Charged to Patients	7,273,667			160,768				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	789,263							88
88.01	RHC II	478,207							88.01
88.02	RHC III	1,125,930							88.02
88.03	RHC IV	1,035,772							88.03
90	Clinic	288,588							90
91	Emergency	6,951,992			6,432				91
92	Observation Beds (Non-Distinct	1,208,303							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	63,796,541			762,492				200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0167** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.451520		691,824			312,372		50
52	Delivery Room & Labor Room	1.488881							52
53	Anesthesiology	0.059732		31,023			1,853		53
54	Radiology-Diagnostic	0.255980		991,920			253,912		54
57	CT Scan	0.073084		981,428			71,727		57
58	MRI	0.168433		384,203			64,712		58
60	Laboratory	0.193901		1,191,303			230,995		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.736035		39,095			28,775		65
66	Physical Therapy	0.423120		375,679			158,957		66
69	Electrocardiology	0.115811		118,911			13,771		69
71	Medical Supplies Charged to Pat	0.335102		62,315			20,882		71
72	Impl. Dev. Charged to Patients	0.410997		116,921			48,054		72
73	Drugs Charged to Patients	0.344150		492,117			169,362		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
88.03	RHC IV								88.03
90	Clinic	0.841192							90
91	Emergency	0.255382		1,105,817			282,406		91
92	Observation Beds (Non-Distinct	0.700088							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.244310							95
200	Subtotal (see instructions)			6,582,556			1,657,778		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			6,582,556			1,657,778		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0167** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,322	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,322	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,710	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,064	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	207.37	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	212.56	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,209,523	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,209,523	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,209,523	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0167** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] PPS [ ] TEFRA [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,382.22	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,470,682	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,470,682	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,985,547	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,456,229	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					126,584	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					155,713	51
52	Total Program excludable cost (sum of lines 50 and 51)					282,297	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					3,173,932	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0167** **WORKSHEET D-1**
PARTS III & IV

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					612	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,382.22	88
89	Observation bed cost (line 87 x line 88) (see instructions)					845,919	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	276,245	3,209,523	0.086070	845,919	72,808	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6049** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[XX] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,312	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,312	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,312	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,685	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,277,139	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,277,139	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,277,139	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6049** **WORKSHEET D-1**
PARTS III & IV

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**		**[ ] TEFRA**
Boxes:	**[ ] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,277,139	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	201.30	71
72	Program routine service cost (line 9 x line 71)	339,191	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	339,191	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	339,191	83
84	Program inpatient ancillary services (see instructions)	299,217	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	638,408	86

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0167** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,322	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,322	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,710	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	218	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	138	15
16	Nursery days (title V or XIX only)	100	16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	207.37	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	212.56	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,209,523	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,209,523	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,209,523	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0167** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,382.22	38
39	Program general inpatient routine service cost (line 9 x line 38)					301,324	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					301,324	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)	356,371	138	2,582.40	100	258,240	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					315,099	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					874,663	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					32,565	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					25,345	51
52	Total Program excludable cost (sum of lines 50 and 51)					57,910	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					816,753	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check Applicable Boxes:
[ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] NF [ ] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					612	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0167** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,174,621		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.451520	849,498	383,565	50
52	Delivery Room & Labor Room	1.488881	818	1,218	52
53	Anesthesiology	0.059732	37,681	2,251	53
54	Radiology-Diagnostic	0.255980	431,265	110,395	54
57	CT Scan	0.073084	650,653	47,552	57
58	MRI	0.168433	11,408	1,921	58
60	Laboratory	0.193901	907,653	175,995	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.736035	315,120	231,939	65
66	Physical Therapy	0.423120	110,949	46,945	66
69	Electrocardiology	0.115811	255,449	29,584	69
71	Medical Supplies Charged to Patients	0.335102	246,617	82,642	71
72	Impl. Dev. Charged to Patients	0.410997	522,946	214,929	72
73	Drugs Charged to Patients	0.344150	1,273,934	438,424	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
88.03	RHC IV				88.03
90	Clinic	0.841192			90
91	Emergency	0.255382	356,085	90,938	91
92	Observation Beds (Non-Distinct Part)	0.700088	181,762	127,249	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		6,151,838	1,985,547	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,151,838		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-U167** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other] [XX] Swing Bed SNF [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [ ] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.451520			50
52	Delivery Room & Labor Room	1.488881			52
53	Anesthesiology	0.059732			53
54	Radiology-Diagnostic	0.255980			54
57	CT Scan	0.073084			57
58	MRI	0.168433			58
60	Laboratory	0.193901			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.736035			65
66	Physical Therapy	0.423120			66
69	Electrocardiology	0.115811			69
71	Medical Supplies Charged to Patients	0.335102			71
72	Impl. Dev. Charged to Patients	0.410997			72
73	Drugs Charged to Patients	0.344150			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
88.03	RHC IV				88.03
90	Clinic	0.841192			90
91	Emergency	0.255382			91
92	Observation Beds (Non-Distinct Part)	0.700088			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-6049** **WORKSHEET D-3**

Check	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.451520			50
52	Delivery Room & Labor Room	1.488881			52
53	Anesthesiology	0.059732			53
54	Radiology-Diagnostic	0.255980	13,902	3,559	54
57	CT Scan	0.073084			57
58	MRI	0.168433			58
60	Laboratory	0.193901	36,178	7,015	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.736035	61	45	65
66	Physical Therapy	0.423120	617,200	261,150	66
69	Electrocardiology	0.115811	170	20	69
71	Medical Supplies Charged to Patients	0.335102	7,713	2,585	71
72	Impl. Dev. Charged to Patients	0.410997			72
73	Drugs Charged to Patients	0.344150	72,187	24,843	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
88.03	RHC IV				88.03
90	Clinic	0.841192			90
91	Emergency	0.255382			91
92	Observation Beds (Non-Distinct Part)	0.700088			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		747,411	299,217	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		747,411		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0167** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V [ ] Title XVIII, Part A [XX] Title XIX
[XX] Hospital [ ] IPF [ ] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] Swing Bed SNF [ ] Swing Bed NF [ ] ICF/IID
[XX] PPS [ ] TEFRA [ ] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		143,181		30
43	Nursery		28,996		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.451520	203,450	91,862	50
52	Delivery Room & Labor Room	1.488881	47,312	70,442	52
53	Anesthesiology	0.059732	11,263	673	53
54	Radiology-Diagnostic	0.255980	43,754	11,200	54
57	CT Scan	0.073084	42,652	3,117	57
58	MRI	0.168433			58
60	Laboratory	0.193901	112,724	21,857	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.736035	26,110	19,218	65
66	Physical Therapy	0.423120	8,529	3,609	66
69	Electrocardiology	0.115811	7,801	903	69
71	Medical Supplies Charged to Patients	0.335102	32,160	10,777	71
72	Impl. Dev. Charged to Patients	0.410997	59,537	24,470	72
73	Drugs Charged to Patients	0.344150	160,768	55,328	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
88.03	RHC IV				88.03
90	Clinic	0.841192			90
91	Emergency	0.255382	6,432	1,643	91
92	Observation Beds (Non-Distinct Part)	0.700088			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		762,492	315,099	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		762,492		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,679,549			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	6,381			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	23.33			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0544			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2183			31
32	Sum of lines 30 and 31	0.2727			32
33	Allowable disproportionate share percentage (see instructions)	0.1171			33
34	Disproportionate share adjustment (see instructions)	78,444			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)			6,406,145,534	35
35.01	Factor 3 (see instructions)	0.000000000		0.000017195	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			141,696	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			141,696	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	141,696			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	2,906,070			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	3,458,058			48
49	Total payment for inpatient operating costs (see instructions)	3,458,058			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	213,547			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	3,671,605			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	3,671,605			61
62	Deductibles billed to program beneficiaries	344,512			62
63	Coinsurance billed to program beneficiaries				63
64	Allowable bad debts (see instructions)	52,322			64
65	Adjusted reimbursable bad debts (see instructions)	34,009			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,322			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,361,102			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	32,137			70.93
70.97	Low volume adjustment for federal fiscal year (2016)	728,421			70.97
71	Amount due provider (see instructions)	4,121,660			71
71.01	Sequestration adjustment (see instructions)	82,433			71.01
72	Interim payments	4,056,258			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-17,031			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2				75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) **EXHIBIT 4**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement					Total (col. 2 through 4)	
		1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments								1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1								1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	2,679,549				2,679,549		2,679,549	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1								1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1								1.04
2	Outlier payments for discharges	6,381				6,381		6,381	2
2.01	Outlier payment for discharges for Model 4 BPCI								2.01
3	Operating outlier reconciliation								3
4	Managed Care Simulated Payments								4
	Indirect Medical Education Adjustment								
5	Amount from Worksheet E Part A, line 21								5
6	IME payment adjustment								6
6.01	IME payment adjustment for managed care								6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7	IME payment adjustment factor								7
8	IME add-on adjustment amount								8
8.01	IME payment adjustment add-on for managed care								8.01
9	Total IME payment (sum of lines 6 and 8)								9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)								9.01
	Disproportionate Share Adjustment								
10	Allowable disproportionate share percentage	0.1171	0.1171	0.1171	0.1171	0.1171	0.1171		10
11	Disproportionate share adjustment	78,444				78,444		78,444	11
11.01	Uncompensated care payments	141,696				141,696		141,696	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	2,906,070				2,906,070		2,906,070	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	3,458,058				3,458,058		3,458,058	14
15	Total payment for inpatient operating costs SCH and MDH only	3,458,058				3,458,058		3,458,058	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	213,547				213,547		213,547	16
17	Special add-on payments for new technologies								17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)								17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG								17.02
18	Capital outlier reconciliation adjustment amount								18
19	**SUBTOTAL**					3,671,605		3,671,605	19
20	Capital DRG other than outlier	212,900				212,900		212,900	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	647				647		647	21
21.01	Model 4 BPCI Capital DRG outlier payments								21.01
22	Indirect medical education percentage								22
23	Indirect medical education adjustment								23
24	Allowable disproportionate share percentage								24
25	Disproportionate share adjustment								25
26	Total prospective capital payments	213,547				213,547		213,547	26
27	**Low volume adjustment factor**					0.198393			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)								28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)					728,421		728,421	29

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0167** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	5,029,337			2
3	PPS payments	4,357,449			3
4	Outlier payment (see instructions)	5,476			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.805			5
6	Line 2 times line 5	4,048,616			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	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)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,362,925			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	36,497			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	832,830			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,493,598			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,493,598			30
31	Primary payer payments	8,117			31
32	Subtotal (line 30 minus line 31)	3,485,481			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	167,395			34
35	Adjusted reimbursable bad debts (see instructions)	108,807			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	167,395			36
37	Subtotal (see instructions)	3,594,288			37
38	MSP-LCC reconciliation amount from PS&R	4			38
39	Other adjustments (specify) (see instructions)	9,846			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,604,130			40
40.01	Sequestration adjustment (see instructions)	72,083			40.01
41	Interim payments	3,560,833			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-28,786			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-6049** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	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)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0167** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				4,056,258		3,560,833	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				4,056,258		3,560,833	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-17,031		-28,786	6.02
7	Total Medicare program liability (see instructions)				4,039,227		3,532,047	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-6049** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				472,344			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				472,344			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-1			6.02
7	Total Medicare program liability (see instructions)				472,343			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	666	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,064	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	73	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,710	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	76,136,995	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	653,500	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	629,960	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	629,960	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	147,977	7
8	Allowable bad debts (see instructions)		8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)		10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	481,983	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	481,983	15
15.01	Sequestration adjustment (see instructions)	9,640	15.01
16	Interim payments	472,344	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	-1	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0167** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[XX] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[ ] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services		1,657,778	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		1,657,778	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		1,657,778	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	762,492	6,582,556	9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	762,492	6,582,556	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	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)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	762,492	6,582,556	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	762,492	4,924,778	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)		1,657,778	21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)		1,657,778	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,657,778	31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		1,657,778	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		1,657,778	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)		1,657,778	40
41	Interim payments		1,657,778	41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	665,758				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	5,489,266				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,095,000				6
7	Inventory	1,030,639				7
8	Prepaid expenses	1,335,203				8
9	Other current assets	844,876				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,270,742				11
	FIXED ASSETS					
12	Land	291,325				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	25,545,657				15
16	Accumulated depreciation	-16,621,803				16
17	Leasehold improvements	483,750				17
18	Accumulated depreciation	-473,078				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	15,980,743				23
24	Accumulated depreciation	-13,677,913				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	11,528,681				30
	OTHER ASSETS					
31	Investments	900,110				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,305,167				34
35	Total other assets (sum of lines 31-34)	9,205,277				35
36	Total assets (sum of lines 11, 30 and 35)	29,004,700				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	2,058,459				37
38	Salaries, wages and fees payable	3,358,049				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,317,025				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	151,000				44
45	Total current liabilities (sum of lines 37 thru 44)	6,884,533				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	3,598,512				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	3,598,512				50
51	Total liabilities (sum of lines 45 and 50)	10,483,045				51
	CAPITAL ACCOUNTS					
52	General fund balance	18,521,655				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	18,521,655				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	29,004,700				60

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		19,957,779			1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,436,124			2
3	Total (sum of line 1 and line 2)		18,521,655			3
4	Additions (credit adjustments) (specify)					4
5	INCREASE IN PERPETUAL TRUST					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		18,521,655			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,521,655			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	INCREASE IN PERPETUAL TRUST					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,084,296		3,084,296	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	2,247,854		2,247,854	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	5,332,150		5,332,150	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	5,332,150		5,332,150	17
18	Ancillary services	8,464,581	43,357,446	51,822,027	18
19	Outpatient services	772,102	7,688,996	8,461,098	19
20	Rural Health Clinic (RHC)		789,263	789,263	20
20.01	RHC II		478,207	478,207	20.01
20.02	RHC III		1,125,930	1,125,930	20.02
20.03	RHC IV		1,035,772	1,035,772	20.03
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		756,271	756,271	22
23	Ambulance	4,986	4,758,122	4,763,108	23
25	ASC				25
26	Hospice		1,513,172	1,513,172	26
27	IROQUOIS WOMENS HEALTH		1,210,814	1,210,814	27
27.01	NURSERY	234,371		234,371	27.01
27.03	PROFESSIONAL FEES	167,806	386,564	554,370	27.03
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	14,975,996	63,100,557	78,076,553	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		35,808,242	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		35,808,242	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	78,076,553	1
2	Less contractual allowances and discounts on patients' accounts	45,873,217	2
3	Net patient revenues (line 1 minus line 2)	32,203,336	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	35,808,242	4
5	Net income from service to patients (line 3 minus line 4)	-3,604,906	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	553,850	6
7	Income from investments	11,717	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	246	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	155,334	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	68	16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	299	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (EHR MEDICARE AND MEDICAID)	-735	24
24.01	Other (TRUST DONATION)	203,236	24.01
24.02	Other (UNREALIZED GAINS)		24.02
24.03	Other (OTHER)	1,244,679	24.03
24.04	Other (GAIN ON DISPOSAL)	88	24.04
25	Total other income (sum of lines 6-24)	2,168,782	25
26	Total (line 5 plus line 25)	-1,436,124	26
29	Net income (or loss) for the period (line 26 minus line 28)	-1,436,124	29

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7586** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	139,756	8,917			67,461	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	273,423	17,445				6
7	Physical Therapy	88,250	5,631		39,852		7
8	Occupational Therapy	19,066	1,216		7,541		8
9	Speech Pathology	1,090	70		334		9
10	Medical Social Services	544	35				10
11	Home Health Aide	38,594	2,462				11
12	Supplies (see instructions)					8,100	12
13	Drugs					656	13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	560,723	35,776		47,727	76,217	24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7586** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	216,134	-6,088	210,046	866	210,912	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	290,868		290,868		290,868	6
7	Physical Therapy	133,733		133,733		133,733	7
8	Occupational Therapy	27,823		27,823		27,823	8
9	Speech Pathology	1,494		1,494		1,494	9
10	Medical Social Services	579		579		579	10
11	Home Health Aide	41,056		41,056		41,056	11
12	Supplies (see instructions)	8,100	-8,099	1		1	12
13	Drugs	656		656		656	13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	720,443	-14,187	706,256	866	707,122	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7586** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	210,912				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	290,868				6
7	Physical Therapy	133,733				7
8	Occupational Therapy	27,823				8
9	Speech Pathology	1,494				9
10	Medical Social Services	579				10
11	Home Health Aide	41,056				11
12	Supplies (see instructions)	1				12
13	Drugs	656				13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	707,122				24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7586** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		210,912	210,912		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		290,868	122,539	413,407	6
7	Physical Therapy		133,733	56,340	190,073	7
8	Occupational Therapy		27,823	11,721	39,544	8
9	Speech Pathology		1,494	629	2,123	9
10	Medical Social Services		579	244	823	10
11	Home Health Aide		41,056	17,296	58,352	11
12	Supplies (see instructions)		1	1,866	1,867	12
13	Drugs		656	277	933	13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		707,122		707,122	24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7586** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-210,912	500,641	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						290,868	6
7	Physical Therapy						133,733	7
8	Occupational Therapy						27,823	8
9	Speech Pathology						1,494	9
10	Medical Social Services						579	10
11	Home Health Aide						41,056	11
12	Supplies (see instructions)					4,429	4,430	12
13	Drugs					2	658	13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-206,481	500,641	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						210,912	25
26	Unit Cost Multiplier						0.421284	26

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7586** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
		0	1	2	4	5.01	5.02	
1	Administrative and General		10,187	9,247	17,147		579	1
2	Skilled Nursing Care	413,407			33,547			2
3	Physical Therapy	190,073			10,828			3
4	Occupational Therapy	39,544			2,339			4
5	Speech Pathology	2,123			134			5
6	Medical Social Services	823			67			6
7	Home Health Aide	58,352			4,735			7
8	Supplies	1,867						8
9	Drugs	933						9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	707,122	10,187	9,247	68,797		579	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7586** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRATIVE AND GENER	MAINTENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	Administrative and General	24,987			62,147	3,826		1
2	Skilled Nursing Care				446,954	27,518		2
3	Physical Therapy				200,901	12,369		3
4	Occupational Therapy				41,883	2,579		4
5	Speech Pathology				2,257	139		5
6	Medical Social Services				890	55		6
7	Home Health Aide				63,087	3,884		7
8	Supplies				1,867	115		8
9	Drugs				933	57		9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	24,987			820,919	50,542		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7586** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General	18,049		5,884				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	18,049		5,884				20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7586** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7586** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	
		20	21	22	23	24	25	
1	Administrative and General					89,906		1
2	Skilled Nursing Care					474,472		2
3	Physical Therapy					213,270		3
4	Occupational Therapy					44,462		4
5	Speech Pathology					2,396		5
6	Medical Social Services					945		6
7	Home Health Aide					66,971		7
8	Supplies					1,982		8
9	Drugs					990		9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)					895,394		20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7586** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS				
		26	27	28				
1	Administrative and General	89,906						1
2	Skilled Nursing Care	474,472	52,959	527,431				2
3	Physical Therapy	213,270	23,805	237,075				3
4	Occupational Therapy	44,462	4,963	49,425				4
5	Speech Pathology	2,396	267	2,663				5
6	Medical Social Services	945	105	1,050				6
7	Home Health Aide	66,971	7,475	74,446				7
8	Supplies	1,982	221	2,203				8
9	Drugs	990	111	1,101				9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	895,394	89,906	895,394				20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.111617					21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7586** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	ADMITTING GROSS CHARGES	PURCHASING RECEIVING AND STORES COST REQ'S	DATA PROCESSING TIME SPENT	
		1	2	4	5.01	5.02	5.03	
1	Administrative and General	1,274	15,594	139,756		10,324	20,003	1
2	Skilled Nursing Care			273,423				2
3	Physical Therapy			88,250				3
4	Occupational Therapy			19,066				4
5	Speech Pathology			1,090				5
6	Medical Social Services			544				6
7	Home Health Aide			38,594				7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	1,274	15,594	560,723		10,324	20,003	20
21	Total cost to be allocated	10,187	9,247	68,797		579	24,987	21
22	Unit Cost Multiplier	7.996075		0.122693		0.056083		22
22	Unit Cost Multiplier		0.592984				1.249163	22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7586** **WORKSHEET H-2 PART II**

	HHA COST CENTER	COMMUNICATIONS # OF PHONES	BUSINESS OFFICE GROSS CHARGES	RECON-CILIATION	OTHER ADMINISTRATIVE AND GENER ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	4A.06	5.06	6	7	
1	Administrative and General				62,147		1,274	1
2	Skilled Nursing Care				446,954			2
3	Physical Therapy				200,901			3
4	Occupational Therapy				41,883			4
5	Speech Pathology				2,257			5
6	Medical Social Services				890			6
7	Home Health Aide				63,087			7
8	Supplies				1,867			8
9	Drugs				933			9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)				820,919		1,274	20
21	Total cost to be allocated				50,542		18,049	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.061568		14.167190	22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7586** **WORKSHEET H-2 PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General		1,274					1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		1,274					20
21	Total cost to be allocated		5,884					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		4.618524					22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7586** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	
		14	15	16	17	19	20	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7586** **WORKSHEET H-2 PART II**

	HHA COST CENTER	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME				
		21	22	23				
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7586** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation

	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2	527,431		527,431	2,675	197.17	1
2	Physical Therapy	3	237,075		237,075	1,362	174.06	2
3	Occupational Therapy	4	49,425		49,425	198	249.62	3
4	Speech Pathology	5	2,663		2,663	71	37.51	4
5	Medical Social Services	6	1,050		1,050	55	19.09	5
6	Home Health Aide	7	74,446		74,446	776	95.94	6
7	Total (sum of lines 1-6)		892,090		892,090	5,137		7

Limitation Cost Comoputation

			Program Visits			
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	99914		1,455		8
8.01	Skilled Nursing Care	16580		137		8.01
8.02	Skilled Nursing Care	19180		178		8.02
9	Physical Therapy	99914		949		9
9.01	Physical Therapy	16580		34		9.01
9.02	Physical Therapy	19180		20		9.02
10	Occupational Therapy	99914		122		10
10.01	Occupational Therapy	16580		1		10.01
10.02	Occupational Therapy	19180		2		10.02
11	Speech Pathology	99914		32		11
11.01	Speech Pathology	16580				11.01
11.02	Speech Pathology	19180				11.02
12	Medical Social Services	99914		30		12
12.01	Medical Social Services	16580				12.01
12.02	Medical Social Services	19180				12.02
13	Home Health Aide	99914		422		13
13.01	Home Health Aide	16580		37		13.01
13.02	Home Health Aide	19180		30		13.02
14	Total (sum of lines 8-13)			3,449		14

Supplies and Drugs Cost Computations

	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	2,203	2,383	4,586	7,111	0.644916	15
16	Cost of Drugs	9	1,101		1,101			16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.423120			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.335102	7,111	2,383	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.344150			col. 2, line 16	5

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7586** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		1,770			348,991		348,991	1
2	Physical Therapy		1,003			174,582		174,582	2
3	Occupational Therapy		125			31,203		31,203	3
4	Speech Pathology		32			1,200		1,200	4
5	Medical Social Services		30			573		573	5
6	Home Health Aide		489			46,915		46,915	6
7	Total (sum of lines 1-6)		3,449			603,464		603,464	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies							15
16	Cost of Drugs							16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7586** **WORKSHEET H-4**
PARTS I & II

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount 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(b)				4
5	Ratio of line 3 to line 4 (not to excced 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		430,552	11
12	Total PPS Reimbursement - Full Episodes with Outliers		22,730	12
13	Total PPS Reimbursement - LUPA Episodes		8,829	13
14	Total PPS Reimbursement - PEP Episodes		4,515	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		12,529	15
16	Total PPS Outlier Reimbursement - PSP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		479,155	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		479,155	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		479,155	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		479,155	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		479,155	31
31.01	Sequestration adjustment (see instructions)		9,583	31.01
32	Interim payments (see instructions)		469,572	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7586** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						469,572	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						469,572	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						469,572	7
8	Name of Contractor			Contractor Number		NPR Date: Month, Day, Year		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0167** **WORKSHEET L**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[XX] PPS** **[ ] Cost Method**

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	212,900	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	647	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	4.75	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)	213,547	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0167** **WORKSHEET L**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[XX] PPS** **[ ] Cost Method**

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMISSIONS							5.01
5.02	PURCHASING, RECEIVING, AND STORES							5.02
5.03	DATA PROCESSING							5.03
5.04	COMMUNICATIONS							5.04
5.05	BUSINESS OFFICE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
88.03	RHC IV							88.03
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
194	IROQUOIS WOMEN'S HEALTH							194
194.01	OTHER NON-REIMBURSABLE COSTS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-3424** **WORKSHEET M-1**

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	376,154		376,154		376,154		376,154	1
2	Physician Assistant								2
3	Nurse Practitioner	139,795		139,795		139,795		139,795	3
4	Visiting Nurse								4
5	Other Nurse	139,679		139,679		139,679		139,679	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	655,628		655,628		655,628		655,628	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		4,210	4,210		4,210		4,210	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		17,471	17,471		17,471		17,471	18
19	Other Health Care Costs		22,032	22,032		22,032		22,032	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		43,713	43,713		43,713		43,713	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	655,628	43,713	699,341		699,341		699,341	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		9,889	9,889		9,889		9,889	29
30	Administrative Costs	47,119	110,168	157,287		157,287	-44,063	113,224	30
31	Total Facility Overhead (sum of lines 29 and 30)	47,119	120,057	167,176		167,176	-44,063	123,113	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	702,747	163,770	866,517		866,517	-44,063	822,454	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3424** **WORKSHEET M-2**

Check applicable box: **[XX] RHC I** **[ ] FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.98	3,432	4,200	4,116		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.80	2,367	2,100	1,680		3
4	Subtotal (sum of lines 1 through 3)	1.78	5,799		5,796	5,799	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.78	5,799			5,799	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	699,341	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	699,341	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	123,113	14
15	Parent provider overhead allocated to facility (see instructions)	225,253	15
16	Total overhead (sum of lines 14 and 15)	348,366	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	348,366	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	348,366	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,047,707	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3424** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,047,707	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	1,600	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,046,107	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,799	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,799	6
7	Adjusted cost per visit (line 3 divided by line 6)	180.39	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	180.39	180.39	180.39	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	526	1,579		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	94,885	284,836		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		379,721		16
16.01	Total program charges (see instructions)(from contractor's records)		244,570		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		283,018		16.04
16.05	Total program cost (see instructions)		283,018		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		25,949		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		43,724		19
20	Net Medicare cost excluding vaccines (see instructions)		283,018		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,053		21
22	Total reimbursable Program cost (line 20 plus line 21)		284,071		22
23	Allowable bad debts (see instructions)		13,545		23
23.01	Adjusted reimbursable bad debts (see instructions)		8,804		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,545		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		292,875		26
26.01	Sequestration adjustment (see instructions)		5,858		26.01
27	Interim payments		249,477		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		37,540		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3424** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	655,628	655,628	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000115	0.000403	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	75	264	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	376	353	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	451	617	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	699,341	699,341	6
7	Total overhead (from Wkst. M-2, line 16)	348,366	348,366	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000645	0.000882	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	225	307	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	676	924	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	21	6	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	32.19	154.00	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	4	6	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	129	924	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		1,600	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,053	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3424

WORKSHEET M-5

Check applicable box: [XX] RHC I [ ] FQHC

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				249,477	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				249,477	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		37,540	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				287,017	

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-3425

WORKSHEET M-1

Check applicable box: **[XX] RHC II** **[ ] FQHC**

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	108,895		108,895		108,895		108,895	1
2	Physician Assistant								2
3	Nurse Practitioner	93,141		93,141		93,141		93,141	3
4	Visiting Nurse								4
5	Other Nurse	67,212		67,212		67,212		67,212	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	269,248		269,248		269,248		269,248	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		2,056	2,056		2,056		2,056	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		3,461	3,461		3,461		3,461	18
19	Other Health Care Costs		10,149	10,149		10,149		10,149	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		15,666	15,666		15,666		15,666	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	269,248	15,666	284,914		284,914		284,914	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		481	481		481		481	29
30	Administrative Costs	38,214	76,436	114,650		114,650	5,265	119,915	30
31	Total Facility Overhead (sum of lines 29 and 30)	38,214	76,917	115,131		115,131	5,265	120,396	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	307,462	92,583	400,045		400,045	5,265	405,310	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3425** **WORKSHEET M-2**

Check applicable box: **[XX] RHC II** **[ ] FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.36	1,728	4,200	1,512		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.90	2,206	2,100	1,890		3
4	Subtotal (sum of lines 1 through 3)	1.26	3,934		3,402	3,934	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.26	3,934			3,934	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	284,914	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	284,914	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	120,396	14
15	Parent provider overhead allocated to facility (see instructions)	162,021	15
16	Total overhead (sum of lines 14 and 15)	282,417	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	282,417	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	282,417	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	567,331	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3425** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC II** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	567,331	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	6,673	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	560,658	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	3,934	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	3,934	6
7	Adjusted cost per visit (line 3 divided by line 6)	142.52	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	142.52	142.52	142.52	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	368	1,103		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	52,447	157,200		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		209,647		16
16.01	Total program charges (see instructions)(from contractor's records)		162,893		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		152,038		16.04
16.05	Total program cost (see instructions)		152,038		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		19,599		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,659		19
20	Net Medicare cost excluding vaccines (see instructions)		152,038		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,569		21
22	Total reimbursable Program cost (line 20 plus line 21)		156,607		22
23	Allowable bad debts (see instructions)		8,573		23
23.01	Adjusted reimbursable bad debts (see instructions)		5,572		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,573		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		162,179		26
26.01	Sequestration adjustment (see instructions)		3,244		26.01
27	Interim payments		163,399		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-4,464		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3425** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC II** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	269,248	269,248	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.004254	0.000421	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,145	113	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	564	1,529	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,709	1,642	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	284,914	284,914	6
7	Total overhead (from Wkst. M-2, line 16)	282,417	282,417	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005998	0.005763	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,694	1,628	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	3,403	3,270	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	9	91	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	378.11	35.93	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	6	64	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,269	2,300	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		6,673	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,569	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3425

WORKSHEET M-5

Check applicable box: [XX] RHC II [ ] FQHC

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				163,399	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				163,399	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02		-4,464	6.02
7	Total Medicare program liability (see instructions)				158,935	

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 15-3979** **WORKSHEET M-1**

Check applicable box: [XX] RHC III [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	267,498		267,498		267,498		267,498	1
2	Physician Assistant								2
3	Nurse Practitioner	151,275		151,275		151,275		151,275	3
4	Visiting Nurse								4
5	Other Nurse	267,827		267,827		267,827		267,827	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	686,600		686,600		686,600		686,600	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		5,676	5,676		5,676		5,676	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		10,989	10,989		10,989		10,989	18
19	Other Health Care Costs		17,740	17,740		17,740		17,740	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		34,405	34,405		34,405		34,405	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	686,600	34,405	721,005		721,005		721,005	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		10,573	10,573		10,573		10,573	29
30	Administrative Costs	73,662	158,238	231,900		231,900	14,803	246,703	30
31	Total Facility Overhead (sum of lines 29 and 30)	73,662	168,811	242,473		242,473	14,803	257,276	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	760,262	203,216	963,478		963,478	14,803	978,281	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 15-3979** **WORKSHEET M-2**

Check applicable box: **[XX] RHC III** **[ ] FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.65	3,723	4,200	2,730		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.30	4,834	2,100	2,730		3
4	Subtotal (sum of lines 1 through 3)	1.95	8,557		5,460	8,557	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.95	8,557			8,557	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	721,005	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	721,005	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	257,276	14
15	Parent provider overhead allocated to facility (see instructions)	303,369	15
16	Total overhead (sum of lines 14 and 15)	560,645	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	560,645	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	560,645	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,281,650	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 15-3979** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC III** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,281,650	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	6,607	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,275,043	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	8,557	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	8,557	6
7	Adjusted cost per visit (line 3 divided by line 6)	149.01	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	149.01	149.01	149.01	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	907	2,721		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	135,152	405,456		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		540,608		16
16.01	Total program charges (see instructions)(from contractor's records)		466,350		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		397,973		16.04
16.05	Total program cost (see instructions)		397,973		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		43,142		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		84,642		19
20	Net Medicare cost excluding vaccines (see instructions)		397,973		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,341		21
22	Total reimbursable Program cost (line 20 plus line 21)		402,314		22
23	Allowable bad debts (see instructions)		7,895		23
23.01	Adjusted reimbursable bad debts (see instructions)		5,132		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,895		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		407,446		26
26.01	Sequestration adjustment (see instructions)		8,149		26.01
27	Interim payments		386,196		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		13,101		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 15-3979** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC III** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	686,600	686,600	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001943	0.000147	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,334	101	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	501	1,781	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,835	1,882	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	721,005	721,005	6
7	Total overhead (from Wkst. M-2, line 16)	560,645	560,645	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002545	0.002610	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,427	1,463	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	3,262	3,345	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	8	106	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	407.75	31.56	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	6	60	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,447	1,894	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		6,607	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,341	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 15-3979

WORKSHEET M-5

Check applicable box: [XX] RHC III [ ] FQHC

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				386,196	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				386,196	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		13,101	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				399,297	

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-8551** **WORKSHEET M-1**

Check applicable box: [XX] RHC IV [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	515,814		515,814	-285,968	229,846		229,846	1
2	Physician Assistant								2
3	Nurse Practitioner	106,433		106,433		106,433		106,433	3
4	Visiting Nurse								4
5	Other Nurse	543,919		543,919	-105,776	438,143		438,143	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	1,166,166		1,166,166	-391,744	774,422		774,422	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		4,616	4,616		4,616		4,616	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		40,231	40,231	-15,257	24,974		24,974	18
19	Other Health Care Costs		33,197	33,197		33,197		33,197	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		78,044	78,044	-15,257	62,787		62,787	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,166,166	78,044	1,244,210	-407,001	837,209		837,209	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		21,044	21,044		21,044		21,044	29
30	Administrative Costs	81,135	368,967	450,102	-107,840	342,262	2,999	345,261	30
31	Total Facility Overhead (sum of lines 29 and 30)	81,135	390,011	471,146	-107,840	363,306	2,999	366,305	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,247,301	468,055	1,715,356	-514,841	1,200,515	2,999	1,203,514	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8551** **WORKSHEET M-2**

Check applicable box: **[XX] RHC IV** **[ ] FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.74	4,831	4,200	7,308		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.74	1,526	2,100	1,554		3
4	Subtotal (sum of lines 1 through 3)	2.48	6,357		8,862	8,862	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	2.48	6,357			8,862	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	837,209	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	837,209	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	366,305	14
15	Parent provider overhead allocated to facility (see instructions)	243,313	15
16	Total overhead (sum of lines 14 and 15)	609,618	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	609,618	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	609,618	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,446,827	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8551** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC IV** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,446,827	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	365	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,446,462	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	8,862	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	8,862	6
7	Adjusted cost per visit (line 3 divided by line 6)	163.22	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	163.22	163.22	163.22	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	520	1,561		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	84,874	254,786		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		339,660		16
16.01	Total program charges (see instructions)(from contractor's records)		239,994		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		262,043		16.04
16.05	Total program cost (see instructions)		262,043		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		12,106		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,578		19
20	Net Medicare cost excluding vaccines (see instructions)		262,043		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				21
22	Total reimbursable Program cost (line 20 plus line 21)		262,043		22
23	Allowable bad debts (see instructions)		14		23
23.01	Adjusted reimbursable bad debts (see instructions)		9		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		14		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		262,052		26
26.01	Sequestration adjustment (see instructions)		5,241		26.01
27	Interim payments		227,982		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		28,829		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8551** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC IV** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	774,422	774,422	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000033	0.000033	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	26	26	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	125	34	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	151	60	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	837,209	837,209	6
7	Total overhead (from Wkst. M-2, line 16)	609,618	609,618	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000180	0.000072	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	110	44	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	261	104	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	2	2	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	130.50	52.00	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		365	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8551

WORKSHEET M-5

Check applicable box: [XX] RHC IV [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				227,982	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				227,982	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		28,829	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				256,811	

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O**

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department		63,227	63,227		63,227		63,227	3
4	Administrative & General	176,815	121,206	298,021	-3,619	294,402	-100	294,302	4
5	Plant Operation & Maintenance		8,041	8,041	-3,566	4,475		4,475	5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary		419	419		419		419	8
9	Nursing Administration	145,825		145,825		145,825		145,825	9
10	Routine Medical Supplies		10,462	10,462		10,462		10,462	10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination		100	100		100		100	13
14	Pharmacy		244,106	244,106	-175,318	68,788		68,788	14
15	Physician Administrative Services								15
16	Other General Service	104	111,204	111,308		111,308	-31,292	80,016	16
17	Patient/Residential Care Services								17
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services	3,026	409	3,435		3,435		3,435	26
27	Nurse Practitioner								27
28	Registered Nurse	405,870	54,909	460,779		460,779		460,779	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	84,945	11,492	96,437		96,437		96,437	37
38	Durable Medical Equipment - Oxygen		11,777	11,777		11,777		11,777	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		1,000	1,000		1,000		1,000	41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
100	TOTAL	816,585	638,352	1,454,937	-182,503	1,272,434	-31,392	1,241,042	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O-1**
HOSPICE CONTINUOUS HOME CARE

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse	48	7	55		55		55	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	10	1	11		11		11	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	58	8	66		66		66	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O-2**
HOSPICE ROUTINE HOME CARE

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services	2,962	401	3,363		3,363		3,363	26
27	Nurse Practitioner								27
28	Registered Nurse	397,257	53,743	451,000		451,000		451,000	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	83,142	11,248	94,390		94,390		94,390	37
38	Durable Medical Equipment - Oxygen		11,777	11,777		11,777		11,777	38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics		1,000	1,000		1,000		1,000	41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	483,361	78,169	561,530		561,530		561,530	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O-3**
HOSPICE INPATIENT RESPITE CARE

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services	10	1	11		11		11	26
27	Nurse Practitioner								27
28	Registered Nurse	1,299	176	1,475		1,475		1,475	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	272	37	309		309		309	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	1,581	214	1,795		1,795		1,795	100

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O-4**
HOSPICE GENERAL INPATIENT CARE

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services	54	7	61		61		61	26
27	Nurse Practitioner								27
28	Registered Nurse	7,266	983	8,249		8,249		8,249	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	1,521	206	1,727		1,727		1,727	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	8,841	1,196	10,037		10,037		10,037	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION **HOSPICE CCN: 14-1616** **WORKSHEET O-5**

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols 1+2)	
		1	2	3	
	GENERAL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt		10,251	10,251	1
2	Cap Rel Costs-Mvble Equip		9,043	9,043	2
3	Employee Benefits Department	63,227	100,190	163,417	3
4	Administrative & General	294,302	135,564	429,866	4
5	Plant Operation & Maintenance	4,475	18,162	22,637	5
6	Laundry & Linen Service				6
7	Housekeeping		5,921	5,921	7
8	Dietary	419		419	8
9	Nursing Administration	145,825		145,825	9
10	Routine Medical Supplies	10,462		10,462	10
11	Medical Records				11
12	Staff Transportation				12
13	Volunteer Service Coordination	100		100	13
14	Pharmacy	68,788		68,788	14
15	Physician Administrative Services				15
16	Other General Service	80,016		80,016	16
17	Patient/Residential Care Services				17
	LEVEL OF CARE				
50	Hospice Continuous Home Care	66		66	50
51	Hospice Routine Home Care	561,530		561,530	51
52	Hospice Inpatient Respite Care	1,795		1,795	52
53	Hospice General Inpatient Care	10,037		10,037	53
	NONREIMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
62	Fundraising				62
63	Hospice/Palliative Medicine Fellows				63
64	Palliative care Program				64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising				67
68	Telehealth / Telemonitoring				68
69	Thrift Store				69
70	Nursing Facility Room & Board				70
71	Other Nonreimbursable				71
99	Negative Cost Center				99
100	TOTAL	1,241,042	279,131	1,520,173	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O-6 PART I**

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPART-MENT	SUBTOTAL	ADMINI-STRATIVE & GENERAL	PLANT OP & MAINT	
		0	1	2	3	3A	4	5	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	10,251	10,251						1
2	Cap Rel Costs-Mvble Equip	9,043		9,043					2
3	Employee Benefits Department	163,417			163,417				3
4	Administrative & General	429,866		9,043		438,909	438,909		4
5	Plant Operation & Maintenance	22,637				22,637	9,189	31,826	5
6	Laundry & Linen Service								6
7	Housekeeping	5,921				5,921	2,403		7
8	Dietary	419				419	170		8
9	Nursing Administration	145,825				145,825	59,194		9
10	Routine Medical Supplies	10,462				10,462	4,247		10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination	100				100	41		13
14	Pharmacy	68,788				68,788	27,923		14
15	Physician Administrative Services								15
16	Other General Service	80,016	10,251			90,267	36,641	31,826	16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care	66				66	27		50
51	Hospice Routine Home Care	561,530			163,417	724,947	294,271		51
52	Hospice Inpatient Respite Care	1,795				1,795	729		52
53	Hospice General Inpatient Care	10,037				10,037	4,074		53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL	1,520,173	10,251	9,043	163,417	1,520,173	438,909	31,826	100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O-6 PART I**

	Descriptions	LAUNDRY & LINEN	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS-PORTATION	
		6	7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping		8,324						7
8	Dietary			589					8
9	Nursing Administration				205,019				9
10	Routine Medical Supplies					14,709			10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service		8,324						16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care				24	2			50
51	Hospice Routine Home Care				200,906	14,413			51
52	Hospice Inpatient Respite Care			60	414	30			52
53	Hospice General Inpatient Care			529	3,675	264			53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL		8,324	589	205,019	14,709			100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS **HOSPICE CCN: 14-1616** **WORKSHEET O-6 PART I**

	Descriptions	VOLUNTEER SVC COOR-DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT/ RES CARE SVCS	TOTAL	
		13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
3	Employee Benefits Department							3
4	Administrative & General							4
5	Plant Operation & Maintenance							5
6	Laundry & Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Routine Medical Supplies							10
11	Medical Records							11
12	Staff Transportation							12
13	Volunteer Service Coordination	141						13
14	Pharmacy		96,711					14
15	Physician Administrative Services							15
16	Other General Service				167,058			16
17	Patient/Residential Care Services							17
	LEVEL OF CARE							
50	Hospice Continuous Home Care		11		20		150	50
51	Hospice Routine Home Care	138	94,772		163,512		1,492,959	51
52	Hospice Inpatient Respite Care	1	195		535		3,759	52
53	Hospice General Inpatient Care	2	1,733		2,991		23,305	53
	NONREIMBURSABLE COST CENTERS							
60	Bereavement Program							60
61	Volunteer Program							61
62	Fundraising							62
63	Hospice/Palliative Medicine Fellows							63
64	Palliative care Program							64
65	Other Physician Services							65
66	Residential Care							66
67	Advertising							67
68	Telehealth / Telemonitoring							68
69	Thrift Store							69
70	Nursing Facility Room & Board							70
71	Other Nonreimbursable							71
99	Negative Cost Center							99
100	TOTAL	141	96,711		167,058		1,520,173	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS **HOSPICE CCN: 14-1616** **WORKSHEET O-6 PART II**

	Descriptions	CAP REL BLDG & FIX SQUARE FEET	CAP REL MVBLE EQUIP DOLLAR VALUE	EMPLOYEE BENEFITS DEPART-MENT GROSS SALARIES	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL ACCUM. COST	PLANT OP & MAINT SQUARE FEET	LAUNDRY & LINEN IN-FACIL-ITY DAYS	
		1	2	3	4A	4	5	6	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	1,282							1
2	Cap Rel Costs-Mvble Equip		15,251						2
3	Employee Benefits Department			816,585					3
4	Administrative & General		15,251		-438,909	1,081,264			4
5	Plant Operation & Maintenance					22,637	1,282		5
6	Laundry & Linen Service								6
7	Housekeeping					5,921			7
8	Dietary					419			8
9	Nursing Administration					145,825			9
10	Routine Medical Supplies					10,462			10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination					100			13
14	Pharmacy					68,788			14
15	Physician Administrative Services								15
16	Other General Service	1,282				90,267	1,282		16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care					66			50
51	Hospice Routine Home Care			816,585		724,947			51
52	Hospice Inpatient Respite Care					1,795			52
53	Hospice General Inpatient Care					10,037			53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	10,251	9,043	163,417		438,909	31,826		100
101	Unit cost multiplier	7.996100	0.592945	0.200122		0.405922	24.825273		101

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS **HOSPICE CCN: 14-1616** **WORKSHEET O-6 PART II**

	Descriptions	HOUSE-KEEPING SQUARE FEET	DIETARY IN-FACIL-ITY DAYS	NURSING ADMINIS-TRATION DIRECT NURS. HRS.	ROUTINE MEDICAL SUPPLIES PATIENT DAYS	MEDICAL RECORDS PATIENT DAYS	STAFF TRANS-PORTATION MILEAGE	VOLUNTEER SVC COOR-DINATION HOURS OF SERVICE	
		7	8	9	10	11	12	13	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping	1,282							7
8	Dietary		168						8
9	Nursing Administration			8,425					9
10	Routine Medical Supplies				8,425				10
11	Medical Records								11
12	Staff Transportation						66,810		12
13	Volunteer Service Coordination							141	13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service	1,282							16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care			1	1		8		50
51	Hospice Routine Home Care			8,256	8,256		65,392	138	51
52	Hospice Inpatient Respite Care		17	17	17		214	1	52
53	Hospice General Inpatient Care		151	151	151		1,196	2	53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	8,324	589	205,019	14,709			141	100
101	Unit cost multiplier	6.492980	3.505952	24.334599	1.745875			1.000000	101

COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS **HOSPICE CCN: 14-1616** **WORKSHEET O-6 PART II**

	Descriptions	PHARMACY CHARGES	PHYSICIAN ADMIN SERVICES PATIENT DAYS	OTHER GENERAL SERVICE SPECIFY BASIS	PATIENT/ RESIDENT CARE SVCS IN-FACIL-ITY DAYS	
		14	15	16	17	
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
3	Employee Benefits Department					3
4	Administrative & General					4
5	Plant Operation & Maintenance					5
6	Laundry & Linen Service					6
7	Housekeeping					7
8	Dietary					8
9	Nursing Administration					9
10	Routine Medical Supplies					10
11	Medical Records					11
12	Staff Transportation					12
13	Volunteer Service Coordination					13
14	Pharmacy	8,425				14
15	Physician Administrative Services		8,435			15
16	Other General Service			8,435		16
17	Patient/Residential Care Services					17
	LEVEL OF CARE					
50	Hospice Continuous Home Care	1	1	1		50
51	Hospice Routine Home Care	8,256	8,256	8,256		51
52	Hospice Inpatient Respite Care	17	27	27		52
53	Hospice General Inpatient Care	151	151	151		53
	NONREIMBURSABLE COST CENTERS					
60	Bereavement Program					60
61	Volunteer Program					61
62	Fundraising					62
63	Hospice/Palliative Medicine Fellows					63
64	Palliative care Program					64
65	Other Physician Services					65
66	Residential Care					66
67	Advertising					67
68	Telehealth / Telemonitoring					68
69	Thrift Store					69
70	Nursing Facility Room & Board					70
71	Other Nonreimbursable					71
99	Negative Cost Center					99
100	Cost to be allocated (per O-6 Pt I)	96,711		167,058		100
101	Unit cost multiplier	11.479050		19.805335		101

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

HOSPICE CCN: 14-1616

WORKSHEET O-7

			Charges by LOC (from Provider Records)					
		Wkst C Pt I, col. 9, line	Cost to Charge Ratio	HCHC	HRHC	HIRC	HGIP	
	Cost Center Descriptions	0	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS							
1	Physical Therapy	66	0.423120					1
2	Occupational Therapy	67						2
3	Speech Language Pathology	68						3
4	Drugs, Biological & Infusion Therapy	73	0.344150					4
5	Durable Medical Equipment/Oxygen	96						5
6	Labs and Diagnostics	60	0.193901					6
7	Medical Supplies	71	0.335102					7
8	Outpatient Services (incl E/R)	93						8
9	Radiation Therapy	55						9
10	Other	76						10
11	Totals (sum of lines 1-10)							11

		Shared Service Costs by LOC				
		HCHC (col 1 x col 2)	HRHC (col 1 x col 3)	HIRC (col 1 x col 4)	HGIP (col 1 x col 5)	
	Cost Center Descriptions	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy					1
2	Occupational Therapy					2
3	Speech Language Pathology					3
4	Drugs, Biological & Infusion Therapy					4
5	Durable Medical Equipment/Oxygen					5
6	Labs and Diagnostics					6
7	Medical Supplies					7
8	Outpatient Services (incl E/R)					8
9	Radiation Therapy					9
10	Other					10
11	Totals (sum of lines 1-10)					11

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2015 To: 09/30/2016	Run Date: 04/12/2017 Run Time: 15:52 Version: 2017.01 (04/05/2017)

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST **HOSPICE CCN: 14-1616** **WORKSHEET O-8**

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	3	
	HOSPICE CONTINUOUS HOME CARE				
1	Total cost			150	1
2	Total unduplicated days			1	2
3	Total average cost per diem			150.00	3
4	Unduplicated program days	1			4
5	Program cost	150			5
	HOSPICE ROUTINE HOME CARE				
6	Total cost			1,492,959	6
7	Total unduplicated days			8,256	7
8	Total average cost per diem			180.83	8
9	Unduplicated program days	7,951	8		9
10	Program cost	1,437,779	1,447		10
	HOSPICE INPATIENT RESPITE CARE				
11	Total cost			3,759	11
12	Total unduplicated days			17	12
13	Total average cost per diem			221.12	13
14	Unduplicated program days	17			14
15	Program cost	3,759			15
	HOSPICE GENERAL INPATIENT CARE				
16	Total cost			23,305	16
17	Total unduplicated days			151	17
18	Total average cost per diem			154.34	18
19	Unduplicated program days	140			19
20	Program cost	21,608			20
	TOTAL HOSPICE CARE				
21	Total cost			1,520,173	21
22	Total unduplicated days			8,425	22
23	Average cost per diem			180.44	23