IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 02/23/2018 Time: 11:22 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IROQUOIS MEMORIAL HOSPITAL (14-0167) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2016 and ending 09/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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		100,962	-23,322			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						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			30,892			10
10.01	HEALTH CLINIC - RHC II			23,920			10.01
10.02	HEALTH CLINIC - RHC III			68,058			10.02
10.03	HEALTH CLINIC - RHC IV			33,420			10.03
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		100,962	132,968			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 / 2016	To: 09 / 30 / 2017	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)	Y	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.	438				62	20	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 / 2016	Ending: 09 / 30 / 2017	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
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)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	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	Y	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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 67. (see instructions)	N			63

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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 is 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 is 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a 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

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

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 care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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)				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

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	02/01/2018	Y	02/01/2018	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	9,125			886	341	1,606	1
2	HMO and other (see instructions)						60	62		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	9,125			886	341	1,606	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						97	132	13
14	Total (see instructions)		25	9,125			886	438	1,738	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	12,775			1,428		9,969	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,077		3,469	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116	1	365						24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					1,695		4,911	26
26.01	RHC II	88.01					1,222		3,359	26.01
26.02	RHC III	88.02					3,234		7,233	26.02
26.03	RHC IV	88.03					2,186		7,580	26.03
27	Total (sum of lines 14-26)		61							27
28	Observation Bed Days							102	640	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
33.01	LTCH site neutral days and discharges									33.01

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)					333	147	658	1
2	HMO and other (see instructions)					24			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)		248.38			333	147	658	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		30.05						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		7.16						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		15.30						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		5.14						26
26.01	RHC II		4.31						26.01
26.02	RHC III		7.65						26.02
26.03	RHC IV		8.53						26.03
27	Total (sum of lines 14-26)		326.52						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	17,285,644		17,285,644	711,076.00	24.31	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		1,697,972		1,697,972	14,197.00	119.60	5
6	Non-physician-Part B		488,760		488,760	8,942.00	54.66	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	1,205,103		1,205,103	64,903.00	18.57	9
10	Excluded area salaries (see instructions)		2,822,800		2,822,800	121,940.00	23.15	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		467,594		467,594	6,536.00	71.54	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)		2,412,267		2,412,267			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		869,949		869,949			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		160,956		160,956			23
24	Wage-related costs (RHC/FQHC)		61,807		61,807			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		136,554		136,554	5,649.75	24.17	26
27	Administrative & General		1,667,083		1,667,083	82,983.42	20.09	27
28	Administrative & General under contract (see instructions)		104,483		104,483	742.55	140.71	28
29	Maintenance & Repairs							29
30	Operation of Plant		264,040		264,040	17,669.25	14.94	30
31	Laundry & Linen Service		27,572		27,572	2,589.71	10.65	31
32	Housekeeping		271,769		271,769	27,858.03	9.76	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		354,727	-160,615	194,112	17,243.92	11.26	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			160,615	160,615	14,267.00	11.26	36
37	Maintenance of Personnel							37
38	Nursing Administration		421,603		421,603	10,706.00	39.38	38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		417,954		417,954	18,745.09	22.30	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		15,203,395		15,203,395	688,679.55	22.08	1
2	Excluded area salaries (see instructions)		4,027,903		4,027,903	186,843.00	21.56	2
3	Subtotal salarles (line 1 minus line 2)		11,175,492		11,175,492	501,836.55	22.27	3
4	Subtotal other wages & related costs (see instructions)		467,594		467,594	6,536.00	71.54	4
5	Subtotal wage-related costs (see instructions)		2,412,267		2,412,267		21.59%	5
6	Total (sum of lines 3 through 5)		14,055,353		14,055,353	508,372.55	27.65	6
7	Total overhead cost (see instructions)		3,665,785		3,665,785	198,454.72	18.47	7

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	1,664,011	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	177,902	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	954,692	17
18	Medicare Taxes - Employers Portion Only	223,275	18
19	Unemployment Insurance	31,243	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	27,341	23
24	Total Wage Related cost (Sum of lines 1-23)	3,078,464	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		2,867			2,867	1
2	Unduplicated Census Count (see instructions)		142.00	26.00	36.00	204.00	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)	0.12		0.12	3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	0.84		0.84	5
6	Direct Nursing Service	2.51		2.51	6
7	Nursing Supervisor	0.63		0.63	7
8	Physical Therapy Service	0.82		0.82	8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	0.22		0.22	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	0.05		0.05	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	0.01		0.01	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.33		1.33	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	799	90	12	21	922	21
22	Skilled Nursing Visit Charges	128,247	14,537	1,938	3,392	148,114	22
23	Physical Therapy Visits	686	26	2		714	23
24	Physical Therapy Visit Charges	110,803	4,200	323		115,326	24
25	Occupational Therapy Visits	124		1		125	25
26	Occupational Therapy Visit Charges	19,705		162		19,867	26
27	Speech Pathology Visits	18				18	27
28	Speech Pathology Visit Charges	2,907				2,907	28
29	Medical Social Service Visits	6				6	29
30	Medical Social Service Visit Charges	1,203		201		1,404	30
31	Home Health Aide Visits	312	16			328	31
32	Home Health Aide Visit Charges	31,281	1,604			32,885	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,945	132	15	21	2,113	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	294,146	20,341	2,624	3,392	320,503	35
36	Total Number of Episodes (standard/non-outlier)	123		19	6	148	36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges	3,397	129	197		3,723	38

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	9		9	8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA	18		18	14
15	RVC	114		114	15
16	RVB	70		70	16
17	RVA	159		159	17
18	RHC	173		173	18
19	RHB	276		276	19
20	RHA	354		354	20
21	RMC	29		29	21
22	RMB	16		16	22
23	RMA	73		73	23
24	RLB	14		14	24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1	14		14	32
33	HC2				33
34	HC1	5		5	34
35	HB2				35
36	HB1	14		14	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1	2		2	44
45	CE2				45
46	CE1	14		14	46
47	CD2				47
48	CD1	7		7	48
49	CC2				49
50	CC1	4		4	50
51	CB2				51
52	CB1	7		7	52
53	CA2				53
54	CA1	31		31	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	8		8	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	10		10	76
77	PA2				77
78	PA1				78
199	AAA	7		7	199
200	TOTAL	1,428		1,428	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	1,205,103	48.75%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	1,113	0.05%	Y	205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	2,471,798			207

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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					10
11	Hospice Routine Home Care	8,141	109	86	8,336	11
12	Hospice Inpatient Respite Care	21			21	12
13	Hospice General Inpatient Care	45	7	11	63	13
14	Total Hospice Days	8,207	116	97	8,420	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	0.413255	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	4,071,988	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	9,992,748	6
7	Medicaid cost (line 1 times line 6)	4,129,553	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.	57,565	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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)	57,565	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	250,971	181,738	432,709	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	103,715	181,738	285,453	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	103,715	181,738	285,453	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,128,508	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	189,368	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	291,336	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	1,837,172	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	861,189	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,146,642	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,204,207	31

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		1,675,763	1,675,763	-641,556	1,034,207	-16,932	1,017,275	1
2	00200	Cap Rel Costs-Mvble Equip				931,099	931,099	-2,382	928,717	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	136,554	2,108,887	2,245,441	249,462	2,494,903	-2,786	2,492,117	4
5.01	00540	ADMISSIONS	296,379	176,401	472,780	-1,556	471,224	-19,067	452,157	5.01
5.02	00550	PURCHASING, RECEIVING, AND STORES	71,784	100,405	172,189	-54,188	118,001		118,001	5.02
5.03	00560	DATA PROCESSING	344,003	370,970	714,973	6,028	721,001		721,001	5.03
5.04	00570	COMMUNICATIONS		79,093	79,093	15,131	94,224		94,224	5.04
5.05	00580	BUSINESS OFFICE	262,425	-51,430	210,995	-602	210,393		210,393	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	692,492	1,991,634	2,684,126	29,351	2,713,477	-1,314,274	1,399,203	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	264,040	901,856	1,165,896	46,082	1,211,978	-12,785	1,199,193	7
8	00800	Laundry & Linen Service	27,572	6,657	34,229		34,229		34,229	8
9	00900	Housekeeping	271,769	48,839	320,608		320,608	-1,482	319,126	9
10	01000	Dietary	354,727	296,724	651,451	-294,823	356,628		356,628	10
11	01100	Cafeteria				294,654	294,654	-163,081	131,573	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	421,603	28,015	449,618	-261	449,357	-262	449,095	13
14	01400	Central Services & Supply		22,496	22,496		22,496	-857	21,639	14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	417,954	74,082	492,036		492,036	-123	491,913	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	1,975,653	457,494	2,433,147	-486,032	1,947,115	-276,451	1,670,664	30
43	04300	Nursery				233,321	233,321		233,321	43
44	04400	Skilled Nursing Facility	1,205,103	252,950	1,458,053	-25,918	1,432,135		1,432,135	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,131,040	1,009,157	2,140,197	-785,432	1,354,765	-410,626	944,139	50
52	05200	Delivery Room & Labor Room				206,324	206,324		206,324	52
53	05300	Anesthesiology		611,551	611,551	-5,092	606,459	-606,340	119	53
54	05400	Radiology-Diagnostic	668,465	778,934	1,447,399	-302,245	1,145,154	-49,113	1,096,041	54
57	05700	CT Scan	123,306	110,116	233,422		233,422	-4,320	229,102	57
58	05800	MRI	57,457	198,889	256,346		256,346		256,346	58
60	06000	Laboratory	602,977	883,747	1,486,724	-1,051	1,485,673		1,485,673	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	472,967	163,960	636,927	-75,278	561,649	-29,110	532,539	65
66	06600	Physical Therapy	593,859	94,578	688,437	-18,032	670,405		670,405	66
69	06900	Electrocardiology	63,678	32,528	96,206	-296	95,910		95,910	69
71	07100	Medical Supplies Charged to Patients				567,328	567,328	-196	567,132	71
72	07200	Impl. Dev. Charged to Patients				735,058	735,058		735,058	72
73	07300	Drugs Charged to Patients	401,206	1,871,081	2,272,287	152,456	2,424,743	-417,031	2,007,712	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	489,294	205,245	694,539	-33,862	660,677		660,677	88
88.01	08801	RHC II	314,663	133,047	447,710	-36,967	410,743		410,743	88.01
88.02	08802	RHC III	711,182	286,527	997,709	-43,230	954,479		954,479	88.02
88.03	08803	RHC IV	853,006	382,124	1,235,130	33,174	1,268,304		1,268,304	88.03
90	09000	Clinic	325,926	-143,670	182,256	-27,617	154,639	-122,106	32,533	90
91	09100	Emergency	911,760	831,372	1,743,132	-39,669	1,703,463	-625,547	1,077,916	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	951,921	259,473	1,211,394	-47,377	1,164,017	-82,333	1,081,684	95
101	10100	Home Health Agency	400,195	223,257	623,452	-7,210	616,242	-374	615,868	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		205,329	205,329	-205,329				113
116	11600	Hospice	816,495	530,127	1,346,622	-152,519	1,194,103	-33,619	1,160,484	116
118		SUBTOTALS (sum of lines 1-117)	16,631,455	17,208,208	33,839,663	213,326	34,052,989	-4,191,197	29,861,792	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		8,522	8,522	16,961	25,483		25,483	190
194	07950	IROQUOIS WOMEN'S HEALTH	361,327	241,076	602,403	-95,835	506,568		506,568	194
194.01	07951	OTHER NON-REIMBURSABLE COSTS	290,621	273,942	564,563	-134,452	430,111		430,111	194.01
194.02	07952	REFERENCE LAB	2,241	220,823	223,064		223,064		223,064	194.02
200		TOTAL (sum of lines 118-199)	17,285,644	17,952,571	35,238,215		35,238,215	-4,191,197	31,047,018	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		873,221	1
500	Total reclassifications					873,221	500
	Code Letter - A						
1	RECLASS ADVERTISING	B	OTHER ADMINISTRATIVE AND GENE	5.06		104,547	1
2			Rural Health Clinic	88		234	2
3							3
4							4
5							5
500	Total reclassifications					104,781	500
	Code Letter - B						
1	RECLASS MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		567,328	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					567,328	500
	Code Letter - C						
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Drugs Charged to Patients	73		152,456	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	Total reclassifications					152,456	500
	Code Letter - D						
1	RECLASS TELEPHONE EXPENSE	E	COMMUNICATIONS	5.04		15,131	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	Total reclassifications					15,131	500
	Code Letter - E						
1	RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		179,994	1
2			Cap Rel Costs-Mvble Equip	2		25,335	2
500	Total reclassifications					205,329	500
	Code Letter - F						
1	RECLASS CAFETERIA	G	Cafeteria	11	160,615	134,039	1
500	Total reclassifications				160,615	134,039	500
	Code Letter - G						
1	RECLASS NURSERY COST	H	Nursery	43	189,631	43,690	1
2			Delivery Room & Labor Room	52	167,689	38,635	2
500	Total reclassifications				357,320	82,325	500
	Code Letter - H						
1	RECLASS OPERATION OF PLANT COST	I	Operation of Plant	7		46,082	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					46,082	500
	Code Letter - I						
1	RECLASS TRANSPORTATION	J	OTHER ADMINISTRATIVE AND GENE	5.06		31,157	1
2							2
500	Total reclassifications					31,157	500
	Code Letter - J						
1	RECLASS IT COST	K	DATA PROCESSING	5.03		8,021	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
16							16
500	Total reclassifications					8,021	500
	Code Letter - K						
1	RECLASS GIFT SHOP	L	Gift, Flower, Coffee Shop & C	190		16,961	1
500	Total reclassifications					16,961	500
	Code Letter - L						
1	RECLASS OTHER CAP RELATED COST	N	Other Cap Rel Costs	3		84,214	1
500	Total reclassifications					84,214	500
	Code Letter - N						
1	RECLASS EMPLOYEE BENEFITS	O	Employee Benefits Department	4		249,704	1
2							2
3							3
4							4
5							5
6							6
7							7
500	Total reclassifications					249,704	500
	Code Letter - O						
1	RECLASS IMPL MED SUPPLIES	P	Impl. Dev. Charged to Patient	72		735,058	1
2							2
500	Total reclassifications					735,058	500
	Code Letter - P						
1	TO RECLASS GENERAL SURGEON	R	RHC IV	88.03	33,174		1
500	Total reclassifications				33,174		500
	Code Letter - R						
	GRAND TOTAL (Increases)				551,109	3,305,807	

(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		873,221	9	1
500	Total reclassifications					873,221		500
	Code letter - A							
1	RECLASS ADVERTISING	B	Adults & Pediatrics	30		176		1
2			RHC III	88.02		279		2
3			Home Health Agency	101		75		3
4			Hospice	116		1,764		4
5			OTHER NON-REIMBURSABLE COSTS	194.01		102,487		5
500	Total reclassifications					104,781		500
	Code letter - B							
1	RECLASS MEDICAL SUPPLIES	C	PURCHASING, RECEIVING, AND ST	5.02		54,137		1
2			Adults & Pediatrics	30		45,821		2
3			Skilled Nursing Facility	44		23,237		3
4			Operating Room	50		214,324		4
5			Anesthesiology	53		5,092		5
6			Radiology-Diagnostic	54		76,455		6
7			Respiratory Therapy	65		75,258		7
8			Physical Therapy	66		2,479		8
9			Electrocardiology	69		296		9
10			Clinic	90		176		10
11			Emergency	91		38,676		11
12			Ambulance Services	95		16,440		12
13			Home Health Agency	101		4,267		13
14			Hospice	116		6,992		14
15			IROQUOIS WOMEN'S HEALTH	194		3,678		15
500	Total reclassifications					567,328		500
	Code letter - C							
1	RECLASS DRUGS CHARGED TO PATIENTS	D	Adults & Pediatrics	30		390		1
2			Skilled Nursing Facility	44		2,638		2
3			Operating Room	50		1,847		3
4			Radiology-Diagnostic	54		3,745		4
5			Laboratory	60		1,051		5
6			Respiratory Therapy	65		20		6
7			Emergency	91		6		7
8			Ambulance Services	95		900		8
9			Home Health Agency	101		322		9
10			Hospice	116		141,537		10
500	Total reclassifications					152,456		500
	Code letter - D							
1	RECLASS TELEPHONE EXPENSE	E	PURCHASING, RECEIVING, AND ST	5.02		51		1
2			DATA PROCESSING	5.03		1,993		2
3			OTHER ADMINISTRATIVE AND GENE	5.06		4,835		3
4			Nursing Administration	13		261		4
5			Operating Room	50		50		5
6			Radiology-Diagnostic	54		644		6
7			Physical Therapy	66		4,668		7
8			Emergency	91		644		8
9			OTHER NON-REIMBURSABLE COSTS	194.01		1,985		9
500	Total reclassifications					15,131		500
	Code letter - E							
1	RECLASS INTEREST EXPENSE	F	Interest Expense	113		205,329	11	1
2							11	2
500	Total reclassifications					205,329		500
	Code letter - F							
1	RECLASS CAFETERIA	G	Dietary	10	160,615	134,039		1
500	Total reclassifications				160,615	134,039		500
	Code letter - G							
1	RECLASS NURSERY COST	H	Adults & Pediatrics	30	357,320	82,325		1
2								2
500	Total reclassifications				357,320	82,325		500
	Code letter - H							
1	RECLASS OPERATION OF PLANT COST	I	Physical Therapy	66		10,496		1
2			Rural Health Clinic	88		5,127		2
3			RHC II	88.01		6,390		3
4			RHC III	88.02		2,170		4
5			Ambulance Services	95		4,692		5
6			Home Health Agency	101		2,196		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		2,196		7
8			IROQUOIS WOMEN'S HEALTH	194		11,230		8
9			OTHER NON-REIMBURSABLE COSTS	194.01		1,585		9
500	Total reclassifications					46,082		500
	Code letter - I							
1	RECLASS TRANSPORTATION	J	Ambulance Services	95		25,345		1
2			OTHER NON-REIMBURSABLE COSTS	194.01		5,812		2
500	Total reclassifications					31,157		500
	Code letter - J							
1	RECLASS IT COST	K	Employee Benefits Department	4		242		1
2			ADMISSIONS	5.01		1,556		2
3			BUSINESS OFFICE	5.05		602		3
4			OTHER ADMINISTRATIVE AND GENE	5.06		343		4
5			Dietary	10		169		5
6			Skilled Nursing Facility	44		43		6
7			Radiology-Diagnostic	54		532		7
8			Physical Therapy	66		389		8
9			Rural Health Clinic	88		395		9
10			RHC II	88.01		784		10
11			RHC III	88.02		395		11
12			Clinic	90		966		12
13			Emergency	91		343		13
14			Home Health Agency	101		350		14
15			Hospice	116		30		15
16			IROQUOIS WOMEN'S HEALTH	194		882		16
500	Total reclassifications					8,021		500
	Code letter - K							
1	RECLASS GIFT SHOP	L	OTHER ADMINISTRATIVE AND GENE	5.06		16,961		1
500	Total reclassifications					16,961		500
	Code letter - L							
1	RECLASS OTHER CAP RELATED COST	N	OTHER ADMINISTRATIVE AND GENE	5.06		84,214	14	1
500	Total reclassifications					84,214		500
	Code letter - N							
1	RECLASS EMPLOYEE BENEFITS	O	Operating Room	50		21,848		1
2			Rural Health Clinic	88		28,574		2
3			RHC II	88.01		29,793		3
4			RHC III	88.02		40,386		4
5			Clinic	90		26,475		5
6			IROQUOIS WOMEN'S HEALTH	194		80,045		6
7			OTHER NON-REIMBURSABLE COSTS	194.01		22,583		7
500	Total reclassifications					249,704		500
	Code letter - O							
1	RECLASS IMPL MED SUPPLIES	P	Operating Room	50		514,189		1
2			Radiology-Diagnostic	54		220,869		2
500	Total reclassifications					735,058		500
	Code letter - P							
1	TO RECLASS GENERAL SURGEON	R	Operating Room	50	33,174			1
500	Total reclassifications				33,174			500
	Code letter - R							
	GRAND TOTAL (Decreases)				551,109	3,305,807		

(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	28,125		28,125		319,450		1
2	Land Improvements								2
3	Buildings and Fixtures	25,545,656	303,583		303,583	77,608	25,771,631		3
4	Building Improvements	483,750					483,750		4
5	Fixed Equipment								5
6	Movable Equipment	15,980,743	838,790		838,790	82,440	16,737,093		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	42,301,474	1,170,498		1,170,498	160,048	43,311,924		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	42,301,474	1,170,498		1,170,498	160,048	43,311,924		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	1,675,763						1,675,763	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	1,675,763						1,675,763	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	26,574,831		26,574,831	0.613568			51,671	51,671	1
2	Cap Rel Costs-Mvble Equ	16,737,093		16,737,093	0.386432			32,543	32,543	2
3	Total (sum of lines 1-2)	43,311,924		43,311,924	1.000000			84,214	84,214	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	802,542		163,062			51,671	1,017,275	1
2	Cap Rel Costs-Mvble Equip	873,221		22,953			32,543	928,717	2
3	Total (sum of lines 1-2)	1,675,763		186,015			84,214	1,945,992	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.)

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	-16,932	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)	B	-2,382	Cap Rel Costs-Mvble Equip	2	11	2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-25	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	-2,001,507				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	-163,081	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-196	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-123	Medical Records & Library	16		18
19	Nursing and allied health education (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	-262	Nursing Administration	13		33
34							34
35							35
36	AMBULANCE TOWNSHIP INCOME	B	-80,523	Ambulance Services	95		36
37							37
38	RENTAL INCOME	B	-122,106	Clinic	90		38
39							39
40	COLLECTION FEES REVENUE	B	-19,067	ADMISSIONS	5.01		40
41	OTHER REVENUE HSKP	B	-1,482	Housekeeping	9		41
42	OTHER REVENUE-CENTRAL SUPPLY	B	-857	Central Services & Supply	14		42
43	OTHER REVENUE-EDUCATION	B	-1,207	Ambulance Services	95		43
44							44
45	MISC INCOME A&G	B	-1,310	OTHER ADMINISTRATIVE AND GENERAL	5.06		45
46	MISC INCOME AUXILLIARY	B	-22,241	OTHER ADMINISTRATIVE AND GENERAL	5.06		46
47	MISC INCOME MED STAFF	B	-8,150	OTHER ADMINISTRATIVE AND GENERAL	5.06		47
48	MISC INCOME EMPL COMMITTEE	B	-5,774	OTHER ADMINISTRATIVE AND GENERAL	5.06		48
48.25	LOBBYING EXPENSE	A	-537	Hospice	116		48.25
49	LOBBYING EXPENSE	A	-374	Home Health Agency	101		49
49.02	PHYSICIAN BENEFIT OFFSET	A	-2,786	Employee Benefits Department	4		49.02
49.03	DONATION EXPENSE	A	-1,635	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.03
49.04	ALCOHOL EXPENSE	A	-2,194	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.04
49.08	ADVERTISING EXPENSE	A	-100,681	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.08
49.09	PHYSICIAN RECRUITMENT	A	-8,654	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.09
49.11	LOBBYING EXPENSE	A	-2,829	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.11
49.12	PROVIDER TAX EXPENSE	A	-1,160,092	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	-33,082	Hospice	116		49.15
49.21	340B DRUGS	A	-181,424	Drugs Charged to Patients	73		49.21
49.22	340B PURCHASED SERVICES	A	-235,607	Drugs Charged to Patients	73		49.22
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,191,197				50

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	276,451	276,451						1
2	50	Operating Room AGGREGATE	410,626	410,626						2
3	53	Anesthesiology AGGREGATE	606,340	606,340						3
4	54	Radiology-Diagnostic AGGREGATE	49,113	49,113						4
5	57	CT Scan AGGREGATE	4,320	4,320						5
6	65	Respiratory Therapy AGGREGATE	29,110	29,110						6
7	91	Emergency AGGREGATE	625,547	625,547						7
8										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	2,001,507	2,001,507						200

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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							276,451	1
2	50	Operating Room AGGREGATE							410,626	2
3	53	Anesthesiology AGGREGATE							606,340	3
4	54	Radiology-Diagnostic AGGREGATE							49,113	4
5	57	CT Scan AGGREGATE							4,320	5
6	65	Respiratory Therapy AGGREGATE							29,110	6
7	91	Emergency AGGREGATE							625,547	7
8										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							2,001,507	200

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	1,017,275	1,017,275					1
2	Cap Rel Costs-Mvble Equip	928,717		928,717				2
4	Employee Benefits Department	2,492,117	5,839	1,963	2,499,919			4
5.01	ADMISSIONS	452,157	5,425	1,642	45,576	504,800		5.01
5.02	PURCHASING, RECEIVING, AND STORES	118,001	11,094	427	11,039		140,561	5.02
5.03	DATA PROCESSING	721,001	3,678	59,179	52,899		399	5.03
5.04	COMMUNICATIONS	94,224	2,450					5.04
5.05	BUSINESS OFFICE	210,393	10,006	549	17,663		139	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,399,203	83,068	7,928	106,488		1,108	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,199,193	98,751	93,103	40,603		2,168	7
8	Laundry & Linen Service	34,229	17,074	123	4,240		223	8
9	Housekeeping	319,126	4,951	138	41,791		2,022	9
10	Dietary	356,628	25,415	2,121	29,850		1,331	10
11	Cafeteria	131,573	7,697		24,699		1,101	11
12	Maintenance of Personnel							12
13	Nursing Administration	449,095	8,711		64,832		16	13
14	Central Services & Supply	21,639	11,138	5,736			1,288	14
15	Pharmacy							15
16	Medical Records & Library	491,913	12,175	135	64,271		80	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	1,670,664	91,861	66,555	208,773	31,132	3,500	30
43	Nursery	233,321	3,456	622	29,161	1,660		43
44	Skilled Nursing Facility	1,432,135	71,160	35,923	185,315	15,302	2,380	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	944,139	127,717	201,366	120,727	40,692	1,065	50
52	Delivery Room & Labor Room	206,324	1,377		25,786	1,468		52
53	Anesthesiology	119	2,472	4,093		1,391	297	53
54	Radiology-Diagnostic	1,096,041	33,896	128,978	100,388	48,501	4,725	54
57	CT Scan	229,102	6,764	103,851	18,961	59,893		57
58	MRI	256,346		343	8,835	12,701		58
60	Laboratory	1,485,673	26,059	18,360	92,723	74,261	25,522	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	532,539	18,569	15,591	72,731	9,520	4,692	65
66	Physical Therapy	670,405	91,498	37,908	91,321	25,171	589	66
69	Electrocardiology	95,910	1,658	6,230	9,792	10,035	25	69
71	Medical Supplies Charged to Patients	567,132				14,840	32,695	71
72	Impl. Dev. Charged to Patients	735,058				10,585	42,361	72
73	Drugs Charged to Patients	2,007,712	13,855	3,094	61,695	58,921	269	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	660,677	19,242	925	75,241		306	88
88.01	RHC II	410,743	20,427	18,246	48,387		190	88.01
88.02	RHC III	954,479	31,173	10,570	109,362		467	88.02
88.03	RHC IV	1,268,304	20,619	14,569	136,272		367	88.03
90	Clinic	32,533	49,535	5,220	26,215	1,982	483	90
91	Emergency	1,077,916	21,944	30,518	140,206	51,845	3,167	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,081,684	1,532	15,054	146,382	34,900	1,133	95
101	Home Health Agency	615,868	9,429	15,776	61,540		360	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	1,160,484	9,488	16,005	125,557		5,341	116
118	SUBTOTALS (sum of lines 1-117)	29,861,792	981,203	922,841	2,399,321	504,800	139,809	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	25,483	6,794				2	190
194	IROQUOIS WOMEN'S HEALTH	506,568	12,197	5,876	55,563		151	194
194.01	OTHER NON-REIMBURSABLE COSTS	430,111	17,081		44,690		599	194.01
194.02	REFERENCE LAB	223,064			345			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	31,047,018	1,017,275	928,717	2,499,919	504,800	140,561	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	837,156						5.03
5.04	COMMUNICATIONS		96,674					5.04
5.05	BUSINESS OFFICE	23,203	2,907	264,860				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	25,495	4,604		1,627,894	1,627,894		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	22,592	2,665		1,459,075	80,738	1,539,813	7
8	Laundry & Linen Service	3,312	242		59,443	3,289	32,989	8
9	Housekeeping	35,620	485		404,133	22,363	9,566	9
10	Dietary	22,048	969		438,362	24,257	49,104	10
11	Cafeteria	18,242	1,211		184,523	10,211	14,871	11
12	Maintenance of Personnel							12
13	Nursing Administration	13,689	3,392		539,735	29,866	16,830	13
14	Central Services & Supply				39,801	2,202	21,521	14
15	Pharmacy							15
16	Medical Records & Library	23,968	11,145		603,687	33,405	23,522	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	74,109	19,627	16,189	2,182,410	120,764	177,484	30
43	Nursery	7,183	1,211	863	277,477	15,354	6,678	43
44	Skilled Nursing Facility	82,988	2,907	7,957	1,836,067	101,599	137,488	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	33,910	9,449	21,161	1,500,226	83,015	246,765	50
52	Delivery Room & Labor Room	6,352	727	763	242,797	13,435	2,660	52
53	Anesthesiology			723	9,095	503	4,776	53
54	Radiology-Diagnostic	35,157	2,907	25,221	1,475,814	81,664	65,491	54
57	CT Scan	5,245	485	31,145	455,446	25,202	13,070	57
58	MRI	3,465	2,181	6,605	290,476	16,073		58
60	Laboratory	40,199	3,392	38,634	1,804,823	99,870	50,348	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	23,585	2,423	4,951	684,601	37,882	35,877	65
66	Physical Therapy	25,985	3,877	13,089	959,843	53,113	176,783	66
69	Electrocardiology	3,184	969	5,218	133,021	7,361	3,203	69
71	Medical Supplies Charged to Patients			7,717	622,384	34,440		71
72	Impl. Dev. Charged to Patients			5,505	793,509	43,909		72
73	Drugs Charged to Patients	18,044	2,423	30,640	2,196,653	121,540	26,768	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	14,206			770,597	42,641	37,178	88
88.01	RHC II	11,900			509,893	28,215	39,466	88.01
88.02	RHC III	21,121			1,127,172	62,372	60,229	88.02
88.03	RHC IV	23,561			1,463,692	80,993	39,838	88.03
90	Clinic	17,625	3,392	1,031	138,016	7,637	95,706	90
91	Emergency	45,232	3,877	26,960	1,401,665	77,561	42,398	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	66,414		18,149	1,365,248	75,546	2,960	95
101	Home Health Agency	19,778			722,751	39,993	18,217	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	42,256	3,392		1,362,523	75,395	18,332	116
118	SUBTOTALS (sum of lines 1-117)	809,668	90,859	262,521	29,682,852	1,552,408	1,470,118	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,211		33,490	1,853	13,127	190
194	IROQUOIS WOMEN'S HEALTH	7,031		2,339	589,725	32,632	23,565	194
194.01	OTHER NON-REIMBURSABLE COSTS	20,228	4,604		517,313	28,626	33,003	194.01
194.02	REFERENCE LAB	229			223,638	12,375		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	837,156	96,674	264,860	31,047,018	1,627,894	1,539,813	202

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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	95,721						8
9	Housekeeping	9,126	445,188					9
10	Dietary	791	16,069	528,583				10
11	Cafeteria		4,867		214,472			11
12	Maintenance of Personnel							12
13	Nursing Administration		5,508		5,750	597,689		13
14	Central Services & Supply		7,043				70,567	14
15	Pharmacy							15
16	Medical Records & Library		7,698		10,062			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	14,966	58,082	99,833	31,103	212,956	2,413	30
43	Nursery	148	2,185		3,014	20,642		43
44	Skilled Nursing Facility	35,007	44,993	390,106	34,835			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,651	80,753	442	14,236	97,442	49,336	50
52	Delivery Room & Labor Room		870		2,666	18,254		52
53	Anesthesiology		1,563					53
54	Radiology-Diagnostic	5,505	21,432		14,757		1,352	54
57	CT Scan		4,277		2,203			57
58	MRI				1,449			58
60	Laboratory	144	16,476		16,879			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		11,741		9,900	67,772	356	65
66	Physical Therapy	5,269	57,853		10,908			66
69	Electrocardiology		1,048		1,333			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		8,760		7,570			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						640	88
88.01	RHC II						308	88.01
88.02	RHC III						648	88.02
88.03	RHC IV		13,037		9,888		1,457	88.03
90	Clinic	1,701	31,320	884	7,396	50,646	332	90
91	Emergency	13,540	13,875	5,503	18,988	129,977	988	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	873	969					95
101	Home Health Agency		5,962					101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		5,999					116
118	SUBTOTALS (sum of lines 1-117)	95,721	422,380	496,768	202,937	597,689	57,830	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,296					190
194	IROQUOIS WOMEN'S HEALTH		7,712		2,956		12,737	194
194.01	OTHER NON-REIMBURSABLE COSTS		10,800	31,815	8,486			194.01
194.02	REFERENCE LAB				93			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	95,721	445,188	528,583	214,472	597,689	70,567	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	678,374						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	46,452	2,946,463		2,946,463			30
43	Nursery	2,477	327,975		327,975			43
44	Skilled Nursing Facility		2,580,095		2,580,095			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	60,718	2,141,584		2,141,584			50
52	Delivery Room & Labor Room	2,191	282,873		282,873			52
53	Anesthesiology	2,075	18,012		18,012			53
54	Radiology-Diagnostic	72,369	1,738,384		1,738,384			54
57	CT Scan	89,366	589,564		589,564			57
58	MRI	18,951	326,949		326,949			58
60	Laboratory	110,871	2,099,411		2,099,411			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	14,205	862,334		862,334			65
66	Physical Therapy	37,557	1,301,326		1,301,326			66
69	Electrocardiology	14,974	160,940		160,940			69
71	Medical Supplies Charged to Patients	22,143	678,967		678,967			71
72	Impl. Dev. Charged to Patients	15,794	853,212		853,212			72
73	Drugs Charged to Patients	87,916	2,449,207		2,449,207			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		851,056		851,056			88
88.01	RHC II		577,882		577,882			88.01
88.02	RHC III		1,250,421		1,250,421			88.02
88.03	RHC IV		1,608,905		1,608,905			88.03
90	Clinic	2,957	336,595		336,595			90
91	Emergency	77,358	1,781,853		1,781,853			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		1,445,596		1,445,596			95
101	Home Health Agency		786,923		786,923			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		1,462,249		1,462,249			116
118	SUBTOTALS (sum of lines 1-117)	678,374	29,458,776		29,458,776			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		52,766		52,766			190
194	IROQUOIS WOMEN'S HEALTH		669,327		669,327			194
194.01	OTHER NON-REIMBURSABLE COSTS		630,043		630,043			194.01
194.02	REFERENCE LAB		236,106		236,106			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	678,374	31,047,018		31,047,018			202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	5,839	1,963	9,814	9,814		4
5.01	ADMISSIONS	7,854	5,425	1,642	14,921	179	15,100	5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,185	11,094	427	12,706	43		5.02
5.03	DATA PROCESSING	2,404	3,678	59,179	65,261	208		5.03
5.04	COMMUNICATIONS		2,450		2,450			5.04
5.05	BUSINESS OFFICE		10,006	549	10,555	69		5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,184	83,068	7,928	92,180	418		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	720	98,751	93,103	192,574	159		7
8	Laundry & Linen Service		17,074	123	17,197	17		8
9	Housekeeping		4,951	138	5,089	164		9
10	Dietary	2,149	25,415	2,121	29,685	117		10
11	Cafeteria	1,778	7,697		9,475	97		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,175	8,711		14,886	255		13
14	Central Services & Supply		11,138	5,736	16,874			14
15	Pharmacy							15
16	Medical Records & Library	3,483	12,175	135	15,793	252		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	91,861	66,555	165,387	816	930	30
43	Nursery		3,456	622	4,078	115	50	43
44	Skilled Nursing Facility	7,526	71,160	35,923	114,609	728	457	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,973	127,717	201,366	338,056	474	1,215	50
52	Delivery Room & Labor Room		1,377		1,377	101	44	52
53	Anesthesiology		2,472	4,093	6,565		42	53
54	Radiology-Diagnostic	42,924	33,896	128,978	205,798	394	1,448	54
57	CT Scan		6,764	103,851	110,615	74	1,788	57
58	MRI			343	343	35	379	58
60	Laboratory	15,974	26,059	18,360	60,393	364	2,244	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,633	18,569	15,591	39,793	286	284	65
66	Physical Therapy	4,384	91,498	37,908	133,790	359	752	66
69	Electrocardiology	343	1,658	6,230	8,231	38	300	69
71	Medical Supplies Charged to Patients						443	71
72	Impl. Dev. Charged to Patients						316	72
73	Drugs Charged to Patients	2,415	13,855	3,094	19,364	242	1,759	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	19,242	925	23,804	296		88
88.01	RHC II	1,941	20,427	18,246	40,614	190		88.01
88.02	RHC III	3,875	31,173	10,570	45,618	430		88.02
88.03	RHC IV	5,564	20,619	14,569	40,752	535		88.03
90	Clinic	1,868	49,535	5,220	56,623	103	59	90
91	Emergency	2,332	21,944	30,518	54,794	551	1,548	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	27,154	1,532	15,054	43,740	575	1,042	95
101	Home Health Agency	5,880	9,429	15,776	31,085	242		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	99,860	9,488	16,005	125,353	493		116
118	SUBTOTALS (sum of lines 1-117)	276,198	981,203	922,841	2,180,242	9,419	15,100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		6,794		6,794			190
194	IROQUOIS WOMEN'S HEALTH	30,466	12,197	5,876	48,539	218		194
194.01	OTHER NON-REIMBURSABLE COSTS		17,081		17,081	176		194.01
194.02	REFERENCE LAB					1		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	306,664	1,017,275	928,717	2,252,656	9,814	15,100	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	12,749						5.02
5.03	DATA PROCESSING	36	65,505					5.03
5.04	COMMUNICATIONS			2,450				5.04
5.05	BUSINESS OFFICE	13	1,816	74	12,527			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	100	1,995	117		94,810		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	197	1,768	68		4,703	199,469	7
8	Laundry & Linen Service	20	259	6		192	4,273	8
9	Housekeeping	183	2,787	12		1,303	1,239	9
10	Dietary	121	1,725	25		1,413	6,361	10
11	Cafeteria	100	1,427	31		595	1,926	11
12	Maintenance of Personnel							12
13	Nursing Administration	1	1,071	86		1,740	2,180	13
14	Central Services & Supply	117				128	2,788	14
15	Pharmacy							15
16	Medical Records & Library	7	1,875	282		1,946	3,047	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	317	5,799	497	767	7,034	22,991	30
43	Nursery		562	31	41	894	865	43
44	Skilled Nursing Facility	216	6,495	74	377	5,918	17,810	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	97	2,653	239	1,003	4,835	31,967	50
52	Delivery Room & Labor Room		497	18	36	783	345	52
53	Anesthesiology	27			34	29	619	53
54	Radiology-Diagnostic	429	2,751	74	1,195	4,757	8,484	54
57	CT Scan		410	12	1,476	1,468	1,693	57
58	MRI		271	55	313	936		58
60	Laboratory	2,315	3,145	86	1,806	5,817	6,522	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	426	1,845	61	235	2,206	4,648	65
66	Physical Therapy	53	2,033	98	620	3,094	22,901	66
69	Electrocardiology	2	249	25	247	429	415	69
71	Medical Supplies Charged to Patients	2,965			366	2,006		71
72	Impl. Dev. Charged to Patients	3,844			261	2,557		72
73	Drugs Charged to Patients	24	1,412	61	1,452	7,070	3,468	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	28	1,112			2,484	4,816	88
88.01	RHC II	17	931			1,643	5,112	88.01
88.02	RHC III	42	1,653			3,633	7,802	88.02
88.03	RHC IV	33	1,844			4,717	5,161	88.03
90	Clinic	44	1,379	86	49	445	12,398	90
91	Emergency	287	3,539	98	1,278	4,518	5,492	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	103	5,197		860	4,400	383	95
101	Home Health Agency	33	1,548			2,329	2,360	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	484	3,306	86		4,391	2,375	116
118	SUBTOTALS (sum of lines 1-117)	12,681	63,354	2,302	12,416	90,413	190,441	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			31		108	1,700	190
194	IROQUOIS WOMEN'S HEALTH	14	550		111	1,901	3,053	194
194.01	OTHER NON-REIMBURSABLE COSTS	54	1,583	117		1,667	4,275	194.01
194.02	REFERENCE LAB		18			721		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	12,749	65,505	2,450	12,527	94,810	199,469	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	21,964						8
9	Housekeeping	2,094	12,871					9
10	Dietary	181	465	40,093				10
11	Cafeteria		141		13,792			11
12	Maintenance of Personnel							12
13	Nursing Administration		159		370	20,748		13
14	Central Services & Supply		204				20,111	14
15	Pharmacy							15
16	Medical Records & Library		223		647			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	3,434	1,679	7,572	2,000	7,391	688	30
43	Nursery	34	63		194	717		43
44	Skilled Nursing Facility	8,034	1,301	29,590	2,240			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,985	2,335	34	915	3,383	14,059	50
52	Delivery Room & Labor Room		25		171	634		52
53	Anesthesiology		45					53
54	Radiology-Diagnostic	1,263	620		949		385	54
57	CT Scan		124		142			57
58	MRI				93			58
60	Laboratory	33	476		1,085			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		339		637	2,353	102	65
66	Physical Therapy	1,209	1,673		701			66
69	Electrocardiology		30		86			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients		253		487			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						182	88
88.01	RHC II						88	88.01
88.02	RHC III						185	88.02
88.03	RHC IV		377		636		415	88.03
90	Clinic	390	906	67	476	1,758	95	90
91	Emergency	3,107	401	417	1,221	4,512	282	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	200	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)	21,964	12,212	37,680	13,050	20,748	16,481	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		124					190
194	IROQUOIS WOMEN'S HEALTH		223		190		3,630	194
194.01	OTHER NON-REIMBURSABLE COSTS		312	2,413	546			194.01
194.02	REFERENCE LAB				6			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,964	12,871	40,093	13,792	20,748	20,111	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	24,072						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	1,648	228,950		228,950			30
43	Nursery	88	7,732		7,732			43
44	Skilled Nursing Facility		187,849		187,849			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,154	405,404		405,404			50
52	Delivery Room & Labor Room	78	4,109		4,109			52
53	Anesthesiology	74	7,435		7,435			53
54	Radiology-Diagnostic	2,568	231,115		231,115			54
57	CT Scan	3,171	120,973		120,973			57
58	MRI	672	3,097		3,097			58
60	Laboratory	3,936	88,222		88,222			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	504	53,719		53,719			65
66	Physical Therapy	1,333	168,616		168,616			66
69	Electrocardiology	531	10,583		10,583			69
71	Medical Supplies Charged to Patients	786	6,566		6,566			71
72	Impl. Dev. Charged to Patients	560	7,538		7,538			72
73	Drugs Charged to Patients	3,119	38,711		38,711			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		32,722		32,722			88
88.01	RHC II		48,595		48,595			88.01
88.02	RHC III		59,363		59,363			88.02
88.03	RHC IV		54,470		54,470			88.03
90	Clinic	105	74,983		74,983			90
91	Emergency	2,745	84,790		84,790			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		56,528		56,528			95
101	Home Health Agency		37,769		37,769			101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice		136,661		136,661			116
118	SUBTOTALS (sum of lines 1-117)	24,072	2,156,500		2,156,500			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,757		8,757			190
194	IROQUOIS WOMEN'S HEALTH		58,429		58,429			194
194.01	OTHER NON-REIMBURSABLE COSTS		28,224		28,224			194.01
194.02	REFERENCE LAB		746		746			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,072	2,252,656		2,252,656			202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	137,452						1
2	Cap Rel Costs-Mvble Equip		1,508,794					2
4	Employee Benefits Department	789	3,189	16,257,002				4
5.01	ADMISSIONS	733	2,667	296,379	65,827,204			5.01
5.02	PURCHASING, RECEIVING, AND STORES	1,499	693	71,784		2,439,084		5.02
5.03	DATA PROCESSING	497	96,143	344,003		6,917	654,724	5.03
5.04	COMMUNICATIONS	331						5.04
5.05	BUSINESS OFFICE	1,352	892	114,865		2,414	18,147	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	11,224	12,880	692,492		19,226	19,939	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	13,343	151,255	264,040		37,613	17,669	7
8	Laundry & Linen Service	2,307	200	27,572		3,868	2,590	8
9	Housekeeping	669	224	271,769		35,081	27,858	9
10	Dietary	3,434	3,445	194,112		23,095	17,243	10
11	Cafeteria	1,040		160,615		19,111	14,267	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,177		421,603		285	10,706	13
14	Central Services & Supply	1,505	9,318			22,350		14
15	Pharmacy							15
16	Medical Records & Library	1,645	219	417,954		1,395	18,745	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	12,412	108,125	1,357,677	4,059,453	60,725	57,959	30
43	Nursery	467	1,011	189,631	216,445		5,618	43
44	Skilled Nursing Facility	9,615	58,360	1,205,103	1,995,304	41,306	64,903	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,257	327,141	785,086	5,306,092	18,477	26,520	50
52	Delivery Room & Labor Room	186		167,689	191,431		4,968	52
53	Anesthesiology	334	6,649		181,316	5,153		53
54	Radiology-Diagnostic	4,580	209,538	652,822	6,324,267	81,985	27,496	54
57	CT Scan	914	168,716	123,306	7,809,690		4,102	57
58	MRI		557	57,457	1,656,129		2,710	58
60	Laboratory	3,521	29,828	602,977	9,687,297	442,871	31,439	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,509	25,329	472,967	1,241,350	81,426	18,445	65
66	Physical Therapy	12,363	61,586	593,859	3,282,115	10,225	20,322	66
69	Electrocardiology	224	10,122	63,678	1,308,535	438	2,490	69
71	Medical Supplies Charged to Patients				1,935,032	567,328		71
72	Impl. Dev. Charged to Patients				1,380,271	735,058		72
73	Drugs Charged to Patients	1,872	5,027	401,206	7,682,961	4,674	14,112	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	1,502	489,294		5,311	11,110	88
88.01	RHC II	2,760	29,643	314,663		3,298	9,307	88.01
88.02	RHC III	4,212	17,172	711,182		8,099	16,518	88.02
88.03	RHC IV	2,786	23,669	886,180		6,376	18,427	88.03
90	Clinic	6,693	8,481	170,477	258,430	8,383	13,784	90
91	Emergency	2,965	49,579	911,760	6,760,293	54,947	35,375	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	207	24,457	951,921	4,550,793	19,667	51,941	95
101	Home Health Agency	1,274	25,629	400,195		6,245	15,468	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,282	26,002	816,495		92,681	33,048	116
118	SUBTOTALS (sum of lines 1-117)	132,578	1,499,248	15,602,813	65,827,204	2,426,028	633,226	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	918				28		190
194	IROQUOIS WOMEN'S HEALTH	1,648	9,546	361,327		2,628	5,499	194
194.01	OTHER NON-REIMBURSABLE COSTS	2,308		290,621		10,400	15,820	194.01
194.02	REFERENCE LAB			2,241			179	194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,017,275	928,717	2,499,919	504,800	140,561	837,156	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.400947	0.615536	0.153775	0.007669	0.057629	1.278640	203
204	Cost to be allocated (Per Wkst. B, Part II)			9,814	15,100	12,749	65,505	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000604	0.000229	0.005227	0.100050	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

	COST CENTER DESCRIPTIONS	COMMUNICATIONS # OF PHONES	BUSINESS OFFICE GROSS CHARGES	RECON-CILIATION	OTHER ADMINISTRATIVE AND GENERAL 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	66,413,785					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	19		-1,627,894	29,419,124			5.06
6	Maintenance & Repairs							6
7	Operation of Plant	11			1,459,075	107,684		7
8	Laundry & Linen Service	1			59,443	2,307	251,780	8
9	Housekeeping	2			404,133	669	24,005	9
10	Dietary	4			438,362	3,434	2,080	10
11	Cafeteria	5			184,523	1,040		11
12	Maintenance of Personnel							12
13	Nursing Administration	14			539,735	1,177		13
14	Central Services & Supply				39,801	1,505		14
15	Pharmacy							15
16	Medical Records & Library	46			603,687	1,645		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	4,059,453		2,182,410	12,412	39,365	30
43	Nursery	5	216,445		277,477	467	390	43
44	Skilled Nursing Facility	12	1,995,304		1,836,067	9,615	92,080	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	39	5,306,092		1,500,226	17,257	22,755	50
52	Delivery Room & Labor Room	3	191,431		242,797	186		52
53	Anesthesiology		181,316		9,095	334		53
54	Radiology-Diagnostic	12	6,324,267		1,475,814	4,580	14,480	54
57	CT Scan	2	7,809,690		455,446	914		57
58	MRI	9	1,656,129		290,476			58
60	Laboratory	14	9,687,297		1,804,823	3,521	380	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10	1,241,350		684,601	2,509		65
66	Physical Therapy	16	3,282,115		959,843	12,363	13,860	66
69	Electrocardiology	4	1,308,535		133,021	224		69
71	Medical Supplies Charged to Patients		1,935,032		622,384			71
72	Impl. Dev. Charged to Patients		1,380,271		793,509			72
73	Drugs Charged to Patients	10	7,682,961		2,196,653	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				770,597	2,600		88
88.01	RHC II				509,893	2,760		88.01
88.02	RHC III				1,127,172	4,212		88.02
88.03	RHC IV				1,463,692	2,786		88.03
90	Clinic	14	258,430		138,016	6,693	4,475	90
91	Emergency	16	6,760,293		1,401,665	2,965	35,615	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		4,550,793		1,365,248	207	2,295	95
101	Home Health Agency				722,751	1,274		101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	14			1,362,523	1,282		116
118	SUBTOTALS (sum of lines 1-117)	375	65,827,204	-1,627,894	28,054,958	102,810	251,780	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5			33,490	918		190
194	IROQUOIS WOMEN'S HEALTH		586,581		589,725	1,648		194
194.01	OTHER NON-REIMBURSABLE COSTS	19			517,313	2,308		194.01
194.02	REFERENCE LAB				223,638			194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	96,674	264,860		1,627,894	1,539,813	95,721	202
203	Unit Cost Multiplier (Wkst. B, Part I)	242.290727	0.003988		0.055335	14.299367	0.380177	203
204	Cost to be allocated (Per Wkst. B, Part II)	2,450	12,527		94,810	199,469	21,964	204
205	Unit Cost Multiplier (Wkst. B, Part II)	6.140351	0.000189		0.003223	1.852355	0.087235	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	95,136						9
10	Dietary	3,434	47,832					10
11	Cafeteria	1,040		18,501				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,177		496	162,669			13
14	Central Services & Supply	1,505				8,715		14
15	Pharmacy							15
16	Medical Records & Library	1,645		868			59,281,107	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	12,412	9,034	2,683	57,959	298	4,059,453	30
43	Nursery	467		260	5,618		216,445	43
44	Skilled Nursing Facility	9,615	35,301	3,005				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,257	40	1,228	26,520	6,093	5,306,092	50
52	Delivery Room & Labor Room	186		230	4,968		191,431	52
53	Anesthesiology	334					181,316	53
54	Radiology-Diagnostic	4,580		1,273		167	6,324,267	54
57	CT Scan	914		190			7,809,690	57
58	MRI			125			1,656,129	58
60	Laboratory	3,521		1,456			9,687,297	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,509		854	18,445	44	1,241,350	65
66	Physical Therapy	12,363		941			3,282,115	66
69	Electrocardiology	224		115			1,308,535	69
71	Medical Supplies Charged to Patients						1,935,032	71
72	Impl. Dev. Charged to Patients						1,380,271	72
73	Drugs Charged to Patients	1,872		653			7,682,961	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					79		88
88.01	RHC II					38		88.01
88.02	RHC III					80		88.02
88.03	RHC IV	2,786		853		180		88.03
90	Clinic	6,693	80	638	13,784	41	258,430	90
91	Emergency	2,965	498	1,638	35,375	122	6,760,293	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)	90,262	44,953	17,506	162,669	7,142	59,281,107	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	918						190
194	IROQUOIS WOMEN'S HEALTH	1,648		255		1,573		194
194.01	OTHER NON-REIMBURSABLE COSTS	2,308	2,879	732				194.01
194.02	REFERENCE LAB			8				194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	445,188	528,583	214,472	597,689	70,567	678,374	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.679490	11.050824	11.592454	3.674265	8.097189	0.011443	203
204	Cost to be allocated (Per Wkst. B, Part II)	12,871	40,093	13,792	20,748	20,111	24,072	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.135291	0.838205	0.745473	0.127547	2.307631	0.000406	205

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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
194.02	REFERENCE LAB							194.02
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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

	COST CENTER DESCRIPTIONS							
204	Cost to be allocated (Per Wkst. B, Part II)							204
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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	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	2,946,463		2,946,463		2,946,463	30
43	Nursery	327,975		327,975		327,975	43
44	Skilled Nursing Facility	2,580,095		2,580,095		2,580,095	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,141,584		2,141,584		2,141,584	50
52	Delivery Room & Labor Room	282,873		282,873		282,873	52
53	Anesthesiology	18,012		18,012		18,012	53
54	Radiology-Diagnostic	1,738,384		1,738,384		1,738,384	54
57	CT Scan	589,564		589,564		589,564	57
58	MRI	326,949		326,949		326,949	58
60	Laboratory	2,099,411		2,099,411		2,099,411	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	862,334		862,334		862,334	65
66	Physical Therapy	1,301,326		1,301,326		1,301,326	66
69	Electrocardiology	160,940		160,940		160,940	69
71	Medical Supplies Charged to Patients	678,967		678,967		678,967	71
72	Impl. Dev. Charged to Patients	853,212		853,212		853,212	72
73	Drugs Charged to Patients	2,449,207		2,449,207		2,449,207	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	851,056		851,056		851,056	88
88.01	RHC II	577,882		577,882		577,882	88.01
88.02	RHC III	1,250,421		1,250,421		1,250,421	88.02
88.03	RHC IV	1,608,905		1,608,905		1,608,905	88.03
90	Clinic	336,595		336,595		336,595	90
91	Emergency	1,781,853		1,781,853		1,781,853	91
92	Observation Beds (Non-Distinct Part)	839,597		839,597		839,597	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,445,596		1,445,596		1,445,596	95
101	Home Health Agency	786,923		786,923		786,923	101
113	Interest Expense						113
116	Hospice	1,462,249		1,462,249		1,462,249	116
200	Subtotal (sum of lines 30 thru 199)	30,298,373		30,298,373		30,298,373	200
201	Less Observation Beds	839,597		839,597		839,597	201
202	Total (line 200 minus line 201)	29,458,776		29,458,776		29,458,776	202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	2,732,298		2,732,298				30
43	Nursery	216,445		216,445				43
44	Skilled Nursing Facility	1,995,304		1,995,304				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,084,166	4,221,926	5,306,092	0.403609	0.403609	0.403609	50
52	Delivery Room & Labor Room	183,480	7,951	191,431	1.477676	1.477676	1.477676	52
53	Anesthesiology	67,401	113,915	181,316	0.099340	0.099340	0.099340	53
54	Radiology-Diagnostic	512,767	5,811,500	6,324,267	0.274875	0.274875	0.274875	54
57	CT Scan	510,138	7,299,552	7,809,690	0.075491	0.075491	0.075491	57
58	MRI	13,174	1,642,955	1,656,129	0.197418	0.197418	0.197418	58
60	Laboratory	998,705	8,688,592	9,687,297	0.216718	0.216718	0.216718	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	408,635	832,715	1,241,350	0.694674	0.694674	0.694674	65
66	Physical Therapy	704,388	2,577,727	3,282,115	0.396490	0.396490	0.396490	66
69	Electrocardiology	272,997	1,035,538	1,308,535	0.122993	0.122993	0.122993	69
71	Medical Supplies Charged to Patients	929,208	1,005,824	1,935,032	0.350882	0.350882	0.350882	71
72	Impl. Dev. Charged to Patients	537,954	842,317	1,380,271	0.618148	0.618148	0.618148	72
73	Drugs Charged to Patients	2,110,139	5,572,822	7,682,961	0.318784	0.318784	0.318784	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		619,050	619,050				88
88.01	RHC II		453,811	453,811				88.01
88.02	RHC III		1,069,224	1,069,224				88.02
88.03	RHC IV		1,394,287	1,394,287				88.03
90	Clinic		258,430	258,430	1.302461	1.302461	1.302461	90
91	Emergency	407,574	6,352,719	6,760,293	0.263576	0.263576	0.263576	91
92	Observation Beds (Non-Distinct Part)	342,716	984,439	1,327,155	0.632629	0.632629	0.632629	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	3,976	4,546,817	4,550,793	0.317658	0.317658	0.317658	95
101	Home Health Agency		502,747	502,747				101
113	Interest Expense							113
116	Hospice		1,418,340	1,418,340				116
200	Subtotal (sum of lines 30 thru 199)	14,031,465	57,253,198	71,284,663				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	14,031,465	57,253,198	71,284,663				202

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	228,950		228,950	2,246	101.94	886	90,319	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	7,732		7,732	132	58.58			43
44	Skilled Nursing Facility	187,849		187,849	9,969	18.84	1,428	26,904	44
45	Nursing Facility								45
200	Total (lines 30-199)	424,531		424,531	12,347		2,314	117,223	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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**

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	405,404	5,306,092	0.076403	527,787	40,325	50
52	Delivery Room & Labor Room	4,109	191,431	0.021465			52
53	Anesthesiology	7,435	181,316	0.041006	21,221	870	53
54	Radiology-Diagnostic	231,115	6,324,267	0.036544	369,881	13,517	54
57	CT Scan	120,973	7,809,690	0.015490	441,068	6,832	57
58	MRI	3,097	1,656,129	0.001870	7,667	14	58
60	Laboratory	88,222	9,687,297	0.009107	770,294	7,015	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	53,719	1,241,350	0.043275	371,573	16,080	65
66	Physical Therapy	168,616	3,282,115	0.051374	76,067	3,908	66
69	Electrocardiology	10,583	1,308,535	0.008088	259,244	2,097	69
71	Medical Supplies Charged to Pat	6,566	1,935,032	0.003393	231,250	785	71
72	Impl. Dev. Charged to Patients	7,538	1,380,271	0.005461	293,246	1,601	72
73	Drugs Charged to Patients	38,711	7,682,961	0.005039	1,292,101	6,511	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	32,722	619,050	0.052858			88
88.01	RHC II	48,595	453,811	0.107082			88.01
88.02	RHC III	59,363	1,069,224	0.055520			88.02
88.03	RHC IV	54,470	1,394,287	0.039067			88.03
90	Clinic	74,983	258,430	0.290148			90
91	Emergency	84,790	6,760,293	0.012542	333,749	4,186	91
92	Observation Beds (Non-Distinct	65,239	1,327,155	0.049157	207,859	10,218	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,566,250	59,868,736		5,203,007	113,959	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	2,246		886		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	132				43
44	Skilled Nursing Facility	9,969		1,428		44
45	Nursing Facility					45
200	Total (lines 30-199)	12,347		2,314		200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	5,306,092			527,787		1,443,673		50
52	Delivery Room & Labor Room	191,431							52
53	Anesthesiology	181,316			21,221		19,598		53
54	Radiology-Diagnostic	6,324,267			369,881		2,623,824		54
57	CT Scan	7,809,690			441,068		2,837,969		57
58	MRI	1,656,129			7,667		516,723		58
60	Laboratory	9,687,297			770,294		1,457,191		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,241,350			371,573		341,104		65
66	Physical Therapy	3,282,115			76,067		9,810		66
69	Electrocardiology	1,308,535			259,244		496,313		69
71	Medical Supplies Charged to Pat	1,935,032			231,250		196,353		71
72	Impl. Dev. Charged to Patients	1,380,271			293,246		519,814		72
73	Drugs Charged to Patients	7,682,961			1,292,101		3,212,335		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	619,050							88
88.01	RHC II	453,811							88.01
88.02	RHC III	1,069,224							88.02
88.03	RHC IV	1,394,287							88.03
90	Clinic	258,430					2,660		90
91	Emergency	6,760,293			333,749		1,701,220		91
92	Observation Beds (Non-Distinct	1,327,155			207,859		549,121		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	59,868,736			5,203,007		15,927,708		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] Hospital** **[ ] SUB (Other)** **[ ] 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	0.403609	1,443,673			582,679			50
52	Delivery Room & Labor Room	1.477676							52
53	Anesthesiology	0.099340	19,598			1,947			53
54	Radiology-Diagnostic	0.274875	2,623,824			721,224			54
57	CT Scan	0.075491	2,837,969			214,241			57
58	MRI	0.197418	516,723			102,010			58
60	Laboratory	0.216718	1,457,191			315,800			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.694674	341,104			236,956			65
66	Physical Therapy	0.396490	9,810			3,890			66
69	Electrocardiology	0.122993	496,313			61,043			69
71	Medical Supplies Charged to Pat	0.350882	196,353			68,897			71
72	Impl. Dev. Charged to Patients	0.618148	519,814			321,322			72
73	Drugs Charged to Patients	0.318784	3,212,335			1,024,041			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	1.302461	2,660			3,465			90
91	Emergency	0.263576	1,701,220			448,401			91
92	Observation Beds (Non-Distinct	0.632629	549,121			347,390			92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.317658							95
200	Subtotal (see instructions)		15,927,708			4,453,306			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		15,927,708			4,453,306			202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	0.403609							50
52	Delivery Room & Labor Room	1.477676							52
53	Anesthesiology	0.099340							53
54	Radiology-Diagnostic	0.274875							54
57	CT Scan	0.075491							57
58	MRI	0.197418							58
60	Laboratory	0.216718							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.694674							65
66	Physical Therapy	0.396490							66
69	Electrocardiology	0.122993							69
71	Medical Supplies Charged to Pat	0.350882							71
72	Impl. Dev. Charged to Patients	0.618148							72
73	Drugs Charged to Patients	0.318784							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	1.302461							90
91	Emergency	0.263576							91
92	Observation Beds (Non-Distinct	0.632629							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.317658							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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	5,306,092							50
52	Delivery Room & Labor Room	191,431							52
53	Anesthesiology	181,316							53
54	Radiology-Diagnostic	6,324,267			6,827				54
57	CT Scan	7,809,690							57
58	MRI	1,656,129							58
60	Laboratory	9,687,297			27,824				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,241,350							65
66	Physical Therapy	3,282,115			478,470				66
69	Electrocardiology	1,308,535			510				69
71	Medical Supplies Charged to Pat	1,935,032			5,308				71
72	Impl. Dev. Charged to Patients	1,380,271							72
73	Drugs Charged to Patients	7,682,961			84,553				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	619,050							88
88.01	RHC II	453,811							88.01
88.02	RHC III	1,069,224							88.02
88.03	RHC IV	1,394,287							88.03
90	Clinic	258,430							90
91	Emergency	6,760,293							91
92	Observation Beds (Non-Distinct	1,327,155			45				92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	59,868,736			603,537				200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	0.403609							50
52	Delivery Room & Labor Room	1.477676							52
53	Anesthesiology	0.099340							53
54	Radiology-Diagnostic	0.274875							54
57	CT Scan	0.075491							57
58	MRI	0.197418							58
60	Laboratory	0.216718							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.694674							65
66	Physical Therapy	0.396490							66
69	Electrocardiology	0.122993							69
71	Medical Supplies Charged to Pat	0.350882							71
72	Impl. Dev. Charged to Patients	0.618148							72
73	Drugs Charged to Patients	0.318784							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	1.302461							90
91	Emergency	0.263576							91
92	Observation Beds (Non-Distinct	0.632629							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.317658							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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	228,950		228,950	2,246	101.94	341	34,762	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	7,732		7,732	132	58.58	97	5,682	43
44	Skilled Nursing Facility	187,849		187,849	9,969	18.84			44
45	Nursing Facility								45
200	Total (lines 30-199)	424,531		424,531	12,347		438	40,444	200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	405,404	5,306,092	0.076403	253,606	19,376	50
52	Delivery Room & Labor Room	4,109	191,431	0.021465	109,491	2,350	52
53	Anesthesiology	7,435	181,316	0.041006	15,017	616	53
54	Radiology-Diagnostic	231,115	6,324,267	0.036544	136,059	4,972	54
57	CT Scan	120,973	7,809,690	0.015490	69,070	1,070	57
58	MRI	3,097	1,656,129	0.001870	5,507	10	58
60	Laboratory	88,222	9,687,297	0.009107	200,587	1,827	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	53,719	1,241,350	0.043275	37,062	1,604	65
66	Physical Therapy	168,616	3,282,115	0.051374	7,623	392	66
69	Electrocardiology	10,583	1,308,535	0.008088	13,243	107	69
71	Medical Supplies Charged to Pat	6,566	1,935,032	0.003393	55,457	188	71
72	Impl. Dev. Charged to Patients	7,538	1,380,271	0.005461	37,916	207	72
73	Drugs Charged to Patients	38,711	7,682,961	0.005039	290,987	1,466	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	32,722	619,050	0.052858			88
88.01	RHC II	48,595	453,811	0.107082			88.01
88.02	RHC III	59,363	1,069,224	0.055520			88.02
88.03	RHC IV	54,470	1,394,287	0.039067			88.03
90	Clinic	74,983	258,430	0.290148			90
91	Emergency	84,790	6,760,293	0.012542	8,224	103	91
92	Observation Beds (Non-Distinct	65,239	1,327,155	0.049157	1,168	57	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,566,250	59,868,736		1,241,017	34,345	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	2,246		341		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	132		97		43
44	Skilled Nursing Facility	9,969				44
45	Nursing Facility					45
200	Total (lines 30-199)	12,347		438		200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	5,306,092			253,606				50
52	Delivery Room & Labor Room	191,431			109,491				52
53	Anesthesiology	181,316			15,017				53
54	Radiology-Diagnostic	6,324,267			136,059				54
57	CT Scan	7,809,690			69,070				57
58	MRI	1,656,129			5,507				58
60	Laboratory	9,687,297			200,587				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,241,350			37,062				65
66	Physical Therapy	3,282,115			7,623				66
69	Electrocardiology	1,308,535			13,243				69
71	Medical Supplies Charged to Pat	1,935,032			55,457				71
72	Impl. Dev. Charged to Patients	1,380,271			37,916				72
73	Drugs Charged to Patients	7,682,961			290,987				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	619,050							88
88.01	RHC II	453,811							88.01
88.02	RHC III	1,069,224							88.02
88.03	RHC IV	1,394,287							88.03
90	Clinic	258,430							90
91	Emergency	6,760,293			8,224				91
92	Observation Beds (Non-Distinct	1,327,155			1,168				92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	59,868,736			1,241,017				200

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	0.403609		662,447			267,370		50
52	Delivery Room & Labor Room	1.477676							52
53	Anesthesiology	0.099340		26,412			2,624		53
54	Radiology-Diagnostic	0.274875		944,117			259,514		54
57	CT Scan	0.075491		1,047,772			79,097		57
58	MRI	0.197418		408,854			80,715		58
60	Laboratory	0.216718		1,144,184			247,965		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.694674		44,870			31,170		65
66	Physical Therapy	0.396490		367,651			145,770		66
69	Electrocardiology	0.122993		141,742			17,433		69
71	Medical Supplies Charged to Pat	0.350882		79,726			27,974		71
72	Impl. Dev. Charged to Patients	0.618148		109,648			67,779		72
73	Drugs Charged to Patients	0.318784		570,645			181,912		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	1.302461							90
91	Emergency	0.263576		1,247,888			328,913		91
92	Observation Beds (Non-Distinct	0.632629		91,413			57,831		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.317658							95
200	Subtotal (see instructions)			6,887,369			1,796,067		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			6,887,369			1,796,067		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	2,246	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,246	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)	1,606	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)	886	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	212.56	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	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)	2,946,463	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)	2,946,463	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)	2,946,463	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	1,311.87	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,162,317	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)	1,162,317	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)	1,732,491	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,894,808	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	90,319	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	113,959	51
52	Total Program excludable cost (sum of lines 50 and 51)	204,278	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,690,530	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
[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)					640	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,311.87	88
89	Observation bed cost (line 87 x line 88) (see instructions)					839,597	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	228,950	2,946,463	0.077703	839,597	65,239	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	9,969	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,969	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)	9,969	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)	1,428	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)	2,580,095	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)	2,580,095	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)	2,580,095	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

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 III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,580,095	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	258.81	71
72	Program routine service cost (line 9 x line 71)	369,581	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)	369,581	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)	369,581	83
84	Program inpatient ancillary services (see instructions)	226,523	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	596,104	86

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	2,246	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,246	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)	1,606	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)	341	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)	132	15
16	Nursery days (title V or XIX only)	97	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	212.56	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	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)	2,946,463	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)	2,946,463	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)	2,946,463	37

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	1,311.87	38
39	Program general inpatient routine service cost (line 9 x line 38)	447,348	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)	447,348	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)	327,975	132	2,484.66	97	241,012	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)	521,776	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,210,136	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	40,444	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	34,345	51
52	Total Program excludable cost (sum of lines 50 and 51)	74,789	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,135,347	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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**
	[ ] 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)	640	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

Check	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] 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		1,057,496		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.403609	527,787	213,020	50
52	Delivery Room & Labor Room	1.477676			52
53	Anesthesiology	0.099340	21,221	2,108	53
54	Radiology-Diagnostic	0.274875	369,881	101,671	54
57	CT Scan	0.075491	441,068	33,297	57
58	MRI	0.197418	7,667	1,514	58
60	Laboratory	0.216718	770,294	166,937	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.694674	371,573	258,122	65
66	Physical Therapy	0.396490	76,067	30,160	66
69	Electrocardiology	0.122993	259,244	31,885	69
71	Medical Supplies Charged to Patients	0.350882	231,250	81,141	71
72	Impl. Dev. Charged to Patients	0.618148	293,246	181,269	72
73	Drugs Charged to Patients	0.318784	1,292,101	411,901	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	1.302461			90
91	Emergency	0.263576	333,749	87,968	91
92	Observation Beds (Non-Distinct Part)	0.632629	207,859	131,498	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		5,203,007	1,732,491	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,203,007		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	0.403609			50
52	Delivery Room & Labor Room	1.477676			52
53	Anesthesiology	0.099340			53
54	Radiology-Diagnostic	0.274875			54
57	CT Scan	0.075491			57
58	MRI	0.197418			58
60	Laboratory	0.216718			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.694674			65
66	Physical Therapy	0.396490			66
69	Electrocardiology	0.122993			69
71	Medical Supplies Charged to Patients	0.350882			71
72	Impl. Dev. Charged to Patients	0.618148			72
73	Drugs Charged to Patients	0.318784			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	1.302461			90
91	Emergency	0.263576			91
92	Observation Beds (Non-Distinct Part)	0.632629			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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[XX] 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	0.403609			50
52	Delivery Room & Labor Room	1.477676			52
53	Anesthesiology	0.099340			53
54	Radiology-Diagnostic	0.274875	6,827	1,877	54
57	CT Scan	0.075491			57
58	MRI	0.197418			58
60	Laboratory	0.216718	27,824	6,030	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.694674			65
66	Physical Therapy	0.396490	478,470	189,709	66
69	Electrocardiology	0.122993	510	63	69
71	Medical Supplies Charged to Patients	0.350882	5,308	1,862	71
72	Impl. Dev. Charged to Patients	0.618148			72
73	Drugs Charged to Patients	0.318784	84,553	26,954	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	1.302461			90
91	Emergency	0.263576			91
92	Observation Beds (Non-Distinct Part)	0.632629	45	28	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		603,537	226,523	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		603,537		202

(A) Worksheet A line numbers

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] 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		215,918		30
43	Nursery		63,269		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.403609	253,606	102,358	50
52	Delivery Room & Labor Room	1.477676	109,491	161,792	52
53	Anesthesiology	0.099340	15,017	1,492	53
54	Radiology-Diagnostic	0.274875	136,059	37,399	54
57	CT Scan	0.075491	69,070	5,214	57
58	MRI	0.197418	5,507	1,087	58
60	Laboratory	0.216718	200,587	43,471	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.694674	37,062	25,746	65
66	Physical Therapy	0.396490	7,623	3,022	66
69	Electrocardiology	0.122993	13,243	1,629	69
71	Medical Supplies Charged to Patients	0.350882	55,457	19,459	71
72	Impl. Dev. Charged to Patients	0.618148	37,916	23,438	72
73	Drugs Charged to Patients	0.318784	290,987	92,762	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	1.302461			90
91	Emergency	0.263576	8,224	2,168	91
92	Observation Beds (Non-Distinct Part)	0.632629	1,168	739	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		1,241,017	521,776	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,241,017		202

(A) Worksheet A line numbers

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)	2,316,446			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)	24,289			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)	23.25			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)	0.0574			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2941			31
32	Sum of lines 30 and 31	0.3515			32
33	Allowable disproportionate share percentage (see instructions)	0.1200			33
34	Disproportionate share adjustment (see instructions)	69,494			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)			5,977,483,147	35
35.01	Factor 3 (see instructions)	0.000000000		0.000020355	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			121,672	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			121,672	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	121,672			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)	2,531,901			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	3,127,314			48
49	Total payment for inpatient operating costs (see instructions)	3,127,314			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	188,119			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)	3,315,433			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	3,315,433			61
62	Deductibles billed to program beneficiaries	310,324			62
63	Coinsurance billed to program beneficiaries	3,948			63
64	Allowable bad debts (see instructions)	69,875			64
65	Adjusted reimbursable bad debts (see instructions)	45,419			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	69,875			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,046,580			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
70.94	HRR adjustment amount (see instructions)	-695			70.94
70.97	Low volume adjustment for federal fiscal year (2017)	657,759			70.97
70.99	HAC adjustment amount (see instructions)	39,725			70.99
71	Amount due provider (see instructions)	3,663,919			71
71.01	Sequestration adjustment (see instructions)	73,278			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	3,489,679			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	100,962			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	2,316,446				2,316,446		2,316,446	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	24,289				24,289		24,289	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	0.1200	0.1200	0.1200	0.1200	0.1200	0.1200		10
11	Disproportionate share adjustment	69,494				69,494		69,494	11
11.01	Uncompensated care payments	121,672				121,672		121,672	11.01
	Additional payment for high percentage of ESRD beneficiary discharges								
12	Total ESRD additional payment								12
13	Subtotal	2,531,901				2,531,901		2,531,901	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	3,127,314				3,127,314		3,127,314	14
15	Total payment for inpatient operating costs SCH and MDH only	3,127,314				3,127,314		3,127,314	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	188,119				188,119		188,119	16
17	Special add-on payments for new technologies								17
17.01	DO NOT USE THIS LINE								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**					3,315,433		3,315,433	19
20	Capital DRG other than outlier	185,759				185,759		185,759	20
20.01	Model 4 BPCI Capital DRG other than outlier								20.01
21	Capital DRG outlier payments	2,360				2,360		2,360	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	188,119				188,119		188,119	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)					657,759		657,759	29

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
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	2,316,446			2,316,446		2,316,446	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	24,289			24,289		24,289	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	0.1200	0.1200	0.1200	0.1200	0.1200		10
11	Disproportionate share adjustment	69,494			69,494		69,494	11
11.01	Uncompensated care payments	121,672			121,672		121,672	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	2,531,901			2,531,901		2,531,901	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	3,127,314			3,127,314		3,127,314	14
15	Total payment for inpatient operating costs SCH and MDH only	3,127,314			3,127,314		3,127,314	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	188,119			188,119		188,119	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							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**				3,315,433		3,315,433	19
20	Capital DRG other than outlier	185,759			185,759		185,759	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	2,360			2,360		2,360	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	188,119			188,119		188,119	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1	657,759			657,759		657,759	29
30	HVBP payment adjustment							30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-695			-695		-695	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				39,725		39,725	32

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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)	4,453,306			2
3	OPPS payments	3,709,358			3
4	Outlier payment (see instructions)	14,374			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.805			5
6	Line 2 times line 5	3,584,911			6
7	Sum of lines 3, 4, and 4.01, 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) (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, 4.01, 8 and 9)	3,723,732			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	32,170			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	704,169			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)	2,987,393			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)	2,987,393			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,987,393			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)	158,655			34
35	Adjusted reimbursable bad debts (see instructions)	103,126			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	158,655			36
37	Subtotal (see instructions)	3,090,519			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)	3,090,519			40
40.01	Sequestration adjustment (see instructions)	61,810			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	3,052,031			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-23,322			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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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) (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, 4.01, 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
40.02	Demonstration payment adjustment amount after sequestration				40.02
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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				3,489,679		3,052,031	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)				3,489,679		3,052,031	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		100,962			6.01
	based on the cost report (1)		.02				-23,322	6.02
7	Total Medicare program liability (see instructions)				3,590,641		3,028,709	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				425,917			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)				425,917			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					6.02
7	Total Medicare program liability (see instructions)				425,917			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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	534,527	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	534,527	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	99,918	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)	434,609	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)	434,609	15
15.01	Sequestration adjustment (see instructions)	8,692	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	425,917	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)		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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		1,796,067	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		1,796,067	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		1,796,067	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	1,241,017	6,887,369	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)	1,241,017	6,887,369	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)	1,241,017	6,887,369	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,241,017	5,091,302	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)		1,796,067	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)		1,796,067	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)		1,796,067	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)		1,796,067	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		1,796,067	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)		1,796,067	40
41	Interim payments		1,796,067	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	1,368,692				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	4,784,973				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,408,000				6
7	Inventory	1,006,920				7
8	Prepaid expenses	1,153,316				8
9	Other current assets	404,181				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	7,310,082				11
	FIXED ASSETS					
12	Land	337,950				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	-14,283,086				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)	10,970,133				30
	OTHER ASSETS					
31	Investments	864,942				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,305,161				34
35	Total other assets (sum of lines 31-34)	9,170,103				35
36	Total assets (sum of lines 11, 30 and 35)	27,450,318				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	4,039,971				37
38	Salaries, wages and fees payable	2,308,269				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,398,805				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	7,747,045				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	3,202,736				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	3,202,736				50
51	Total liabilities (sum of lines 45 and 50)	10,949,781				51
	CAPITAL ACCOUNTS					
52	General fund balance	16,500,537				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)	16,500,537				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	27,450,318				60

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		18,521,655			1
2	Net income (loss) (from Worksheet G-3, line 29)		-2,021,118			2
3	Total (sum of line 1 and line 2)		16,500,537			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)		16,500,537			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)		16,500,537			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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	2,732,298		2,732,298	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	2,471,798		2,471,798	7
8	Nursing facility	2,471,798		2,471,798	8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	7,675,894		7,675,894	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)	7,675,894		7,675,894	17
18	Ancillary services	5,225,214	47,325,657	52,550,871	18
19	Outpatient services	750,290		750,290	19
20	Rural Health Clinic (RHC)		619,050	619,050	20
20.01	RHC II		453,811	453,811	20.01
20.02	RHC III		1,069,224	1,069,224	20.02
20.03	RHC IV		1,394,287	1,394,287	20.03
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		502,747	502,747	22
23	Ambulance	3,976	4,546,817	4,550,793	23
25	ASC				25
26	Hospice		1,513,172	1,513,172	26
27	IROQUOIS WOMENS HEALTH		586,581	586,581	27
27.01	NURSERY	216,445		216,445	27.01
27.03	PROFESSIONAL FEES	159,646	87,492	247,138	27.03
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	14,031,465	58,098,838	72,130,303	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		35,238,215	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)		35,238,215	43

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	72,130,303	1
2	Less contractual allowances and discounts on patients' accounts	41,939,271	2
3	Net patient revenues (line 1 minus line 2)	30,191,032	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	35,238,215	4
5	Net income from service to patients (line 3 minus line 4)	-5,047,183	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	1,052,412	6
7	Income from investments	198,313	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	25	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	163,081	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	196	16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	123	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)		24
24.01	Other (TRUST DONATION)		24.01
24.02	Other (UNREALIZED GAINS)		24.02
24.03	Other (OTHER)	1,611,915	24.03
24.04	Other (GAIN ON DISPOSAL)		24.04
25	Total other income (sum of lines 6-24)	3,026,065	25
26	Total (line 5 plus line 25)	-2,021,118	26
29	Net income (or loss) for the period (line 26 minus line 28)	-2,021,118	29

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	91,284	5,990			39,912	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	199,908	13,118				6
7	Physical Therapy	52,395	3,438		127,333		7
8	Occupational Therapy	11,320	743		24,094		8
9	Speech Pathology	647	42		1,068		9
10	Medical Social Services	323	22				10
11	Home Health Aide	44,318	2,908				11
12	Supplies (see instructions)					4,267	12
13	Drugs					322	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)	400,195	26,261		152,495	44,501	24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	137,186	-2,621	134,565	-374	134,191	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	213,026		213,026		213,026	6
7	Physical Therapy	183,166		183,166		183,166	7
8	Occupational Therapy	36,157		36,157		36,157	8
9	Speech Pathology	1,757		1,757		1,757	9
10	Medical Social Services	345		345		345	10
11	Home Health Aide	47,226		47,226		47,226	11
12	Supplies (see instructions)	4,267	-4,267				12
13	Drugs	322	-322				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)	623,452	-7,210	616,242	-374	615,868	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	134,191				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	213,026				6
7	Physical Therapy	183,166				7
8	Occupational Therapy	36,157				8
9	Speech Pathology	1,757				9
10	Medical Social Services	345				10
11	Home Health Aide	47,226				11
12	Supplies (see instructions)					12
13	Drugs					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)	615,868				24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		134,191	134,191		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		213,026	58,879	271,905	6
7	Physical Therapy		183,166	50,625	233,791	7
8	Occupational Therapy		36,157	9,993	46,150	8
9	Speech Pathology		1,757	486	2,243	9
10	Medical Social Services		345	95	440	10
11	Home Health Aide		47,226	13,053	60,279	11
12	Supplies (see instructions)			1,059	1,059	12
13	Drugs			1	1	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)		615,868		615,868	24

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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					-134,191	485,511	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						213,026	6
7	Physical Therapy						183,166	7
8	Occupational Therapy						36,157	8
9	Speech Pathology						1,757	9
10	Medical Social Services						345	10
11	Home Health Aide						47,226	11
12	Supplies (see instructions)					3,832	3,832	12
13	Drugs					2	2	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)					-130,357	485,511	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						134,191	25
26	Unit Cost Multiplier						0.276391	26

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		9,429	15,776	14,037		360	1
2	Skilled Nursing Care	271,905			30,741			2
3	Physical Therapy	233,791			8,057			3
4	Occupational Therapy	46,150			1,741			4
5	Speech Pathology	2,243			99			5
6	Medical Social Services	440			50			6
7	Home Health Aide	60,279			6,815			7
8	Supplies	1,059						8
9	Drugs	1						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)	615,868	9,429	15,776	61,540		360	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.

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	MAIN-TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	Administrative and General	19,778			59,380	3,286		1
2	Skilled Nursing Care				302,646	16,746		2
3	Physical Therapy				241,848	13,382		3
4	Occupational Therapy				47,891	2,650		4
5	Speech Pathology				2,342	130		5
6	Medical Social Services				490	27		6
7	Home Health Aide				67,094	3,713		7
8	Supplies				1,059	59		8
9	Drugs				1			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)	19,778			722,751	39,993		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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	18,217		5,962				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)	18,217		5,962				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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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					86,845		1
2	Skilled Nursing Care					319,392		2
3	Physical Therapy					255,230		3
4	Occupational Therapy					50,541		4
5	Speech Pathology					2,472		5
6	Medical Social Services					517		6
7	Home Health Aide					70,807		7
8	Supplies					1,118		8
9	Drugs					1		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)					786,923		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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	86,845						1
2	Skilled Nursing Care	319,392	39,620	359,012				2
3	Physical Therapy	255,230	31,661	286,891				3
4	Occupational Therapy	50,541	6,270	56,811				4
5	Speech Pathology	2,472	307	2,779				5
6	Medical Social Services	517	64	581				6
7	Home Health Aide	70,807	8,784	79,591				7
8	Supplies	1,118	139	1,257				8
9	Drugs	1		1				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)	786,923	86,845	786,923				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.		0.124050					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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	25,629	91,284		6,245	15,468	1
2	Skilled Nursing Care			199,908				2
3	Physical Therapy			52,395				3
4	Occupational Therapy			11,320				4
5	Speech Pathology			647				5
6	Medical Social Services			323				6
7	Home Health Aide			44,318				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	25,629	400,195		6,245	15,468	20
21	Total cost to be allocated	9,429	15,776	61,540		360	19,778	21
22	Unit Cost Multiplier	7.401099		0.153775		0.057646		22
22	Unit Cost Multiplier		0.615553				1.278640	22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				59,380		1,274	1
2	Skilled Nursing Care				302,646			2
3	Physical Therapy				241,848			3
4	Occupational Therapy				47,891			4
5	Speech Pathology				2,342			5
6	Medical Social Services				490			6
7	Home Health Aide				67,094			7
8	Supplies				1,059			8
9	Drugs				1			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)				722,751		1,274	20
21	Total cost to be allocated				39,993		18,217	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				0.055334		14.299058	22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		5,962					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		4.679749					22

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	359,012		359,012	1,705	210.56	1
2	Physical Therapy	3	286,891		286,891	1,013	283.21	2
3	Occupational Therapy	4	56,811		56,811	163	348.53	3
4	Speech Pathology	5	2,779		2,779	27	102.93	4
5	Medical Social Services	6	581		581	5	116.20	5
6	Home Health Aide	7	79,591		79,591	556	143.15	6
7	Total (sum of lines 1-6)		785,665		785,665	3,469		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		893		8
8.01	Skilled Nursing Care	16580		29		8.01
8.02	Skilled Nursing Care	19180				8.02
9	Physical Therapy	99914		703		9
9.01	Physical Therapy	16580		11		9.01
9.02	Physical Therapy	19180				9.02
10	Occupational Therapy	99914		121		10
10.01	Occupational Therapy	16580		4		10.01
10.02	Occupational Therapy	19180				10.02
11	Speech Pathology	99914		18		11
11.01	Speech Pathology	16580				11.01
11.02	Speech Pathology	19180				11.02
12	Medical Social Services	99914		6		12
12.01	Medical Social Services	16580				12.01
12.02	Medical Social Services	19180				12.02
13	Home Health Aide	99914		257		13
13.01	Home Health Aide	16580		71		13.01
13.02	Home Health Aide	19180				13.02
14	Total (sum of lines 8-13)			2,113		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	1,257	1,629	2,886	4,643	0.621581	15
16	Cost of Drugs	9	1		1			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	0.396490			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	0.350882	4,643	1,629	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.318784			col. 2, line 16	5

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		922			194,136		194,136	1
2	Physical Therapy		714			202,212		202,212	2
3	Occupational Therapy		125			43,566		43,566	3
4	Speech Pathology		18			1,853		1,853	4
5	Medical Social Services		6			697		697	5
6	Home Health Aide		328			46,953		46,953	6
7	Total (sum of lines 1-6)		2,113			489,417		489,417	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		322,369	11
12	Total PPS Reimbursement - Full Episodes with Outliers		10,580	12
13	Total PPS Reimbursement - LUPA Episodes		2,391	13
14	Total PPS Reimbursement - PEP Episodes		1,916	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		2,211	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)		339,467	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		339,467	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		339,467	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)		339,467	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		339,467	31
31.01	Sequestration adjustment (see instructions)		6,789	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		332,678	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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						332,678	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)						332,678	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)						332,678	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	185,759	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	2,360	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)	4.48	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)	188,119	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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
194.02	REFERENCE LAB							194.02
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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	250,013		250,013		250,013		250,013	1
2	Physician Assistant								2
3	Nurse Practitioner	115,267		115,267		115,267		115,267	3
4	Visiting Nurse								4
5	Other Nurse	92,912		92,912		92,912		92,912	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)	458,192		458,192		458,192		458,192	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		2,657	2,657		2,657		2,657	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		18,509	18,509		18,509		18,509	18
19	Other Health Care Costs		8,106	8,106		8,106		8,106	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		29,272	29,272		29,272		29,272	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	458,192	29,272	487,464		487,464		487,464	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		11,184	11,184	-5,127	6,057		6,057	29
30	Administrative Costs	31,102	164,789	195,891	-28,735	167,156		167,156	30
31	Total Facility Overhead (sum of lines 29 and 30)	31,102	175,973	207,075	-33,862	173,213		173,213	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	489,294	205,245	694,539	-33,862	660,677		660,677	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	0.79	2,768	4,200	3,318		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.82	2,143	2,100	1,722		3
4	Subtotal (sum of lines 1 through 3)	1.61	4,911		5,040	5,040	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)	1.61	4,911			5,040	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)	487,464	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)	487,464	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)	173,213	14
15	Parent provider overhead allocated to facility (see instructions)	190,379	15
16	Total overhead (sum of lines 14 and 15)	363,592	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	363,592	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	363,592	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	851,056	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	851,056	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	7,317	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	843,739	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,040	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,040	6
7	Adjusted cost per visit (line 3 divided by line 6)	167.41	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)	167.41	167.41	167.41	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	424	1,273		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	70,982	213,113		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)		284,095		16
16.01	Total program charges (see instructions)(from contractor's records)		197,635		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		194		16.02
16.03	Total program preventive costs (see instructions)		279		16.03
16.04	Total program non-preventive costs (see instructions)		205,412		16.04
16.05	Total program cost (see instructions)		205,691		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		27,051		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		34,078		19
20	Net Medicare cost excluding vaccines (see instructions)		205,691		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,155		21
22	Total reimbursable Program cost (line 20 plus line 21)		210,846		22
23	Allowable bad debts (see instructions)		16,025		23
23.01	Adjusted reimbursable bad debts (see instructions)		10,416		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,025		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		221,262		26
26.01	Sequestration adjustment (see instructions)		4,425		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		185,945		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		30,892		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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	458,192	458,192	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000027	0.002637	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	12	1,208	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	79	2,892	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	91	4,100	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	487,464	487,464	6
7	Total overhead (from Wkst. M-2, line 16)	363,592	363,592	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000187	0.008411	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	68	3,058	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	159	7,158	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	1	96	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	159.00	74.56	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	1	67	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	159	4,996	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)		7,317	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)		5,155	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				185,945	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)				185,945	
	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		30,892	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				216,837	

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	88,211		88,211		88,211		88,211	1
2	Physician Assistant								2
3	Nurse Practitioner	103,656		103,656		103,656		103,656	3
4	Visiting Nurse								4
5	Other Nurse	85,856		85,856		85,856		85,856	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)	277,723		277,723		277,723		277,723	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		1,650	1,650		1,650		1,650	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		3,657	3,657		3,657		3,657	18
19	Other Health Care Costs		8,391	8,391		8,391		8,391	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		13,698	13,698		13,698		13,698	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	277,723	13,698	291,421		291,421		291,421	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		5,069	5,069	-5,069				29
30	Administrative Costs	36,940	114,280	151,220	-31,898	119,322		119,322	30
31	Total Facility Overhead (sum of lines 29 and 30)	36,940	119,349	156,289	-36,967	119,322		119,322	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	314,663	133,047	447,710	-36,967	410,743		410,743	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	0.33	1,261	4,200	1,386		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.85	2,098	2,100	1,785		3
4	Subtotal (sum of lines 1 through 3)	1.18	3,359		3,171	3,359	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)	1.18	3,359			3,359	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)	291,421	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)	291,421	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)	119,322	14
15	Parent provider overhead allocated to facility (see instructions)	167,139	15
16	Total overhead (sum of lines 14 and 15)	286,461	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	286,461	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	286,461	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	577,882	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	577,882	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	8,416	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	569,466	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	3,359	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	3,359	6
7	Adjusted cost per visit (line 3 divided by line 6)	169.53	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)	169.53	169.53	169.53	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	308	922		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	52,215	156,307		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)		208,522		16
16.01	Total program charges (see instructions)(from contractor's records)		146,923		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,084		16.02
16.03	Total program preventive costs (see instructions)		1,538		16.03
16.04	Total program non-preventive costs (see instructions)		149,795		16.04
16.05	Total program cost (see instructions)		151,333		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		19,740		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,220		19
20	Net Medicare cost excluding vaccines (see instructions)		151,333		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,735		21
22	Total reimbursable Program cost (line 20 plus line 21)		157,068		22
23	Allowable bad debts (see instructions)		13,397		23
23.01	Adjusted reimbursable bad debts (see instructions)		8,708		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,397		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		165,776		26
26.01	Sequestration adjustment (see instructions)		3,316		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		138,540		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		23,920		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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	277,723	277,723	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000317	0.003870	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	88	1,075	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	550	2,531	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	638	3,606	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	291,421	291,421	6
7	Total overhead (from Wkst. M-2, line 16)	286,461	286,461	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002189	0.012374	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	627	3,545	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	1,265	7,151	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	7	84	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	180.71	85.13	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	3	61	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	542	5,193	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)		8,416	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)		5,735	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				138,540	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)				138,540	
	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		23,920	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				162,460	

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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	165,049		165,049		165,049		165,049	3
4	Visiting Nurse								4
5	Other Nurse	236,597		236,597		236,597		236,597	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)	669,144		669,144		669,144		669,144	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		4,063	4,063		4,063		4,063	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		20,573	20,573		20,573		20,573	18
19	Other Health Care Costs		12,848	12,848		12,848		12,848	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		37,484	37,484		37,484		37,484	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	669,144	37,484	706,628		706,628		706,628	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		13,342	13,342	-2,170	11,172		11,172	29
30	Administrative Costs	42,038	235,701	277,739	-41,060	236,679		236,679	30
31	Total Facility Overhead (sum of lines 29 and 30)	42,038	249,043	291,081	-43,230	247,851		247,851	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	711,182	286,527	997,709	-43,230	954,479		954,479	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	3,549	4,200	2,730		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.50	3,684	2,100	3,150		3
4	Subtotal (sum of lines 1 through 3)	2.15	7,233		5,880	7,233	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)	2.15	7,233			7,233	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)	706,628	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)	706,628	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)	247,851	14
15	Parent provider overhead allocated to facility (see instructions)	295,942	15
16	Total overhead (sum of lines 14 and 15)	543,793	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	543,793	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	543,793	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,250,421	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	1,250,421	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	6,330	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,244,091	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	7,233	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	7,233	6
7	Adjusted cost per visit (line 3 divided by line 6)	172.00	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)	172.00	172.00	172.00	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	812	2,437		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	139,664	419,164		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)		558,828		16
16.01	Total program charges (see instructions)(from contractor's records)		442,692		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,398		16.02
16.03	Total program preventive costs (see instructions)		1,765		16.03
16.04	Total program non-preventive costs (see instructions)		404,967		16.04
16.05	Total program cost (see instructions)		406,732		16.05
17	Primary payer payments		100		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		50,854		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		78,088		19
20	Net Medicare cost excluding vaccines (see instructions)		406,632		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,571		21
22	Total reimbursable Program cost (line 20 plus line 21)		411,203		22
23	Allowable bad debts (see instructions)		8,436		23
23.01	Adjusted reimbursable bad debts (see instructions)		5,483		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,436		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		416,686		26
26.01	Sequestration adjustment (see instructions)		8,334		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		340,294		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		68,058		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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	669,144	669,144	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000245	0.001053	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	164	705	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,021	1,687	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,185	2,392	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	706,628	706,628	6
7	Total overhead (from Wkst. M-2, line 16)	543,793	543,793	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001677	0.003385	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	912	1,841	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,097	4,233	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	13	56	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	161.31	75.59	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	11	37	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,774	2,797	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)		6,330	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)		4,571	16

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				340,294	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)				340,294	
	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		68,058	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				408,352	

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: 14-8551** **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	518,814		518,814	33,174	551,988		551,988	1
2	Physician Assistant								2
3	Nurse Practitioner	104,788		104,788		104,788		104,788	3
4	Visiting Nurse								4
5	Other Nurse	193,232		193,232		193,232		193,232	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)	816,834		816,834	33,174	850,008		850,008	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		13,217	13,217		13,217		13,217	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		19,913	19,913		19,913		19,913	18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		33,130	33,130		33,130		33,130	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	816,834	33,130	849,964	33,174	883,138		883,138	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		13,294	13,294		13,294		13,294	29
30	Administrative Costs	36,173	335,699	371,872		371,872		371,872	30
31	Total Facility Overhead (sum of lines 29 and 30)	36,173	348,993	385,166		385,166		385,166	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	853,007	382,123	1,235,130	33,174	1,268,304		1,268,304	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	1.64	5,072	4,200	6,888		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.97	2,508	2,100	2,037		3
4	Subtotal (sum of lines 1 through 3)	2.61	7,580		8,925	8,925	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)	2.61	7,580			8,925	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)	883,138	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)	883,138	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)	385,166	14
15	Parent provider overhead allocated to facility (see instructions)	340,601	15
16	Total overhead (sum of lines 14 and 15)	725,767	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	725,767	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	725,767	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,608,905	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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	1,608,905	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,608,905	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	8,925	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	8,925	6
7	Adjusted cost per visit (line 3 divided by line 6)	180.27	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)	180.27	180.27	180.27	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	548	1,644		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	98,788	296,364		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)		395,152		16
16.01	Total program charges (see instructions)(from contractor's records)		251,035		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,007		16.02
16.03	Total program preventive costs (see instructions)		1,585		16.03
16.04	Total program non-preventive costs (see instructions)		293,218		16.04
16.05	Total program cost (see instructions)		294,803		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		27,044		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		44,597		19
20	Net Medicare cost excluding vaccines (see instructions)		294,803		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)		294,803		22
23	Allowable bad debts (see instructions)		24,948		23
23.01	Adjusted reimbursable bad debts (see instructions)		16,216		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,948		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		311,019		26
26.01	Sequestration adjustment (see instructions)		6,220		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		271,379		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		33,420		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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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)	850,008	850,008	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	883,138	883,138	6
7	Total overhead (from Wkst. M-2, line 16)	725,767	725,767	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)			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)			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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				271,379	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)				271,379	
	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		33,420	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				304,799	

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 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		64,143	64,143		64,143		64,143	3
4	Administrative & General	198,590	114,222	312,812	-1,794	311,018	-537	310,481	4
5	Plant Operation & Maintenance		7,458	7,458	-2,196	5,262		5,262	5
6	Laundry & Linen Service								6
7	Housekeeping								7
8	Dietary		195	195		195		195	8
9	Nursing Administration	88,222		88,222		88,222		88,222	9
10	Routine Medical Supplies				-6,992	-6,992		-6,992	10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination		100	100		100		100	13
14	Pharmacy		224,348	224,348	-141,537	82,811		82,811	14
15	Physician Administrative Services								15
16	Other General Service	38,614	77,977	116,591		116,591	-33,082	83,509	16
17	Patient/Residential Care Services								17
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services	2,233	153	2,386		2,386		2,386	26
27	Nurse Practitioner	663	45	708		708		708	27
28	Registered Nurse	403,337	27,673	431,010		431,010		431,010	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	84,836	5,821	90,657		90,657		90,657	37
38	Durable Medical Equipment - Oxygen		6,992	6,992		6,992		6,992	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	816,495	530,127	1,346,622	-152,519	1,194,103	-33,619	1,160,484	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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								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								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								100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	2,210	152	2,362		2,362		2,362	26
27	Nurse Practitioner	656	45	701		701		701	27
28	Registered Nurse	399,313	27,397	426,710		426,710		426,710	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	83,989	5,762	89,751		89,751		89,751	37
38	Durable Medical Equipment - Oxygen		6,992	6,992		6,992		6,992	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	486,168	41,348	527,516		527,516		527,516	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	6		6		6		6	26
27	Nurse Practitioner	2		2		2		2	27
28	Registered Nurse	1,006	69	1,075		1,075		1,075	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	212	15	227		227		227	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	1,226	84	1,310		1,310		1,310	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	17	1	18		18		18	26
27	Nurse Practitioner	5		5		5		5	27
28	Registered Nurse	3,018	207	3,225		3,225		3,225	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	635	44	679		679		679	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	3,675	252	3,927		3,927		3,927	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		9,488	9,488	1
2	Cap Rel Costs-Mvble Equip		16,005	16,005	2
3	Employee Benefits Department	64,143	125,557	189,700	3
4	Administrative & General	310,481	126,384	436,865	4
5	Plant Operation & Maintenance	5,262	18,332	23,594	5
6	Laundry & Linen Service				6
7	Housekeeping		5,999	5,999	7
8	Dietary	195		195	8
9	Nursing Administration	88,222		88,222	9
10	Routine Medical Supplies	-6,992		-6,992	10
11	Medical Records				11
12	Staff Transportation				12
13	Volunteer Service Coordination	100		100	13
14	Pharmacy	82,811		82,811	14
15	Physician Administrative Services				15
16	Other General Service	83,509		83,509	16
17	Patient/Residential Care Services				17
	LEVEL OF CARE				
50	Hospice Continuous Home Care				50
51	Hospice Routine Home Care	527,516		527,516	51
52	Hospice Inpatient Respite Care	1,310		1,310	52
53	Hospice General Inpatient Care	3,927		3,927	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	1,160,484	301,765	1,462,249	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	9,488	9,488						1
2	Cap Rel Costs-Mvble Equip	16,005		16,005					2
3	Employee Benefits Department	189,700			189,700				3
4	Administrative & General	436,865		16,005		452,870	452,870		4
5	Plant Operation & Maintenance	23,594				23,594	10,513	34,107	5
6	Laundry & Linen Service								6
7	Housekeeping	5,999				5,999	2,673		7
8	Dietary	195				195	87		8
9	Nursing Administration	88,222				88,222	39,310		9
10	Routine Medical Supplies	-6,992				-6,992			10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination	100				100	45		13
14	Pharmacy	82,811				82,811	36,899		14
15	Physician Administrative Services								15
16	Other General Service	83,509	9,488			92,997	41,437	34,107	16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care	527,516			189,700	717,216	319,572		51
52	Hospice Inpatient Respite Care	1,310				1,310	584		52
53	Hospice General Inpatient Care	3,927				3,927	1,750		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	1,462,249	9,488	16,005	189,700	1,462,249	452,870	34,107	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		8,672						7
8	Dietary			282					8
9	Nursing Administration				127,532				9
10	Routine Medical Supplies					-6,992			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		8,672						16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care				126,260				51
52	Hospice Inpatient Respite Care			71	318				52
53	Hospice General Inpatient Care			211	954				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					-6,992			99
100	TOTAL		8,672	282	127,532	-6,992			100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	145						13
14	Pharmacy		119,710					14
15	Physician Administrative Services							15
16	Other General Service				177,213			16
17	Patient/Residential Care Services							17
	LEVEL OF CARE							
50	Hospice Continuous Home Care							50
51	Hospice Routine Home Care	142	118,515		175,445		1,457,150	51
52	Hospice Inpatient Respite Care	1	299		442		3,025	52
53	Hospice General Inpatient Care	2	896		1,326		9,066	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						-6,992	99
100	TOTAL	145	119,710		177,213		1,462,249	100

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		26,002						2
3	Employee Benefits Department			816,495					3
4	Administrative & General		26,002		-452,870	1,016,371			4
5	Plant Operation & Maintenance					23,594	1,282		5
6	Laundry & Linen Service								6
7	Housekeeping					5,999			7
8	Dietary					195			8
9	Nursing Administration					88,222			9
10	Routine Medical Supplies				6,992				10
11	Medical Records								11
12	Staff Transportation								12
13	Volunteer Service Coordination					100			13
14	Pharmacy					82,811			14
15	Physician Administrative Services								15
16	Other General Service	1,282				92,997	1,282		16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care			816,495		717,216			51
52	Hospice Inpatient Respite Care					1,310			52
53	Hospice General Inpatient Care					3,927			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)	9,488	16,005	189,700		452,870	34,107		100
101	Unit cost multiplier	7.400936	0.615530	0.232335		0.445575	26.604524		101

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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		84						8
9	Nursing Administration			8,420					9
10	Routine Medical Supplies				8,420				10
11	Medical Records								11
12	Staff Transportation						33,692		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								50
51	Hospice Routine Home Care			8,336	8,336		33,356	138	51
52	Hospice Inpatient Respite Care		21	21	21		84	1	52
53	Hospice General Inpatient Care		63	63	63		252	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)	8,672	282	127,532	-6,992			145	100
101	Unit cost multiplier	6.764431	3.357143	15.146318				1.028369	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	8,420				14
15	Physician Administrative Services		8,420			15
16	Other General Service			8,420		16
17	Patient/Residential Care Services					17
	LEVEL OF CARE					
50	Hospice Continuous Home Care					50
51	Hospice Routine Home Care	8,336	8,336	8,336		51
52	Hospice Inpatient Respite Care	21	21	21		52
53	Hospice General Inpatient Care	63	63	63		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)	119,710		177,213		100
101	Unit cost multiplier	14.217340		21.046675		101

IROQUOIS MEMORIAL HOSPITAL Provider CCN: 14-0167	In Lieu of Form **CMS-2552-10**	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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	0.396490					1
2	Occupational Therapy	67						2
3	Speech Language Pathology	68						3
4	Drugs, Biological & Infusion Therapy	73	0.318784					4
5	Durable Medical Equipment/Oxygen	96						5
6	Labs and Diagnostics	60	0.216718					6
7	Medical Supplies	71	0.350882					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: 10/01/2016 To: 09/30/2017	Run Date: 02/23/2018 Run Time: 11:22 Version: 2018.01 (02/20/2018)

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				1
2	Total unduplicated days				2
3	Total average cost per diem				3
4	Unduplicated program days				4
5	Program cost				5
	HOSPICE ROUTINE HOME CARE				
6	Total cost			1,457,150	6
7	Total unduplicated days			8,336	7
8	Total average cost per diem			174.80	8
9	Unduplicated program days	8,141	109		9
10	Program cost	1,423,047	19,053		10
	HOSPICE INPATIENT RESPITE CARE				
11	Total cost			3,025	11
12	Total unduplicated days			21	12
13	Total average cost per diem			144.05	13
14	Unduplicated program days	21			14
15	Program cost	3,025			15
	HOSPICE GENERAL INPATIENT CARE				
16	Total cost			9,066	16
17	Total unduplicated days			63	17
18	Total average cost per diem			143.90	18
19	Unduplicated program days	45	7		19
20	Program cost	6,476	1,007		20
	TOTAL HOSPICE CARE				
21	Total cost			1,469,241	21
22	Total unduplicated days			8,420	22
23	Average cost per diem			174.49	23